

1 IN THE UNITED STATES DISTRICT COURT
 2 FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
 3 CHARLESTON DIVISION

4 * * * * *

5 B.P.J., by her next friend and *
 6 Mother, HEATHER JACKSON, *
 7 Plaintiff * Case No.
 8 vs. * 2:21-CV-00316

9 WEST VIRGINIA STATE BOARD OF *
 10 EDUCATION, HARRISON COUNTY *
 11 BOARD OF EDUCATION, WEST *
 12 VIRGINIA SECONDARY SCHOOL *
 13 ACTIVITIES COMMISSION, W. *

14 CLAYTON BURCH in his official *
 15 Capacity as State Superintendent, * VIDEOTAPED
 16 DORA STUTLER in her official * VIDEOCONFERENCE
 17 Capacity as Harrison County * DEPOSITION
 18 Superintendent, PATRICK MORRISEY * OF

19 In his official capacity as * ARON JANSSEN, M.D.
 20 Attorney General, and THE STATE * April 4, 2022
 21 OF WEST VIRGINIA, *
 22 Defendants *

23 Any reproduction of this transcript
 24 is prohibited without authorization
 by the certifying agency.

1 VIDEOTAPED VIDEOCONFERENCE DEPOSITION
2 OF
3 ARON JANSSEN, M.D., taken on behalf of the Defendant,
4 State of West Virginia herein, pursuant to the Rules of
5 Civil Procedure, taken before me, the undersigned, Lacey
6 C. Scott, a Court Reporter and Notary Public in and for
7 the State of West Virginia, on Thursday, April 4, 2022,
8 beginning at 9:09 a.m.

9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

A P P E A R A N C E S

JOSHUA BLOCK, ESQUIRE

American Civil Liberties Union Foundation

125 Broad Street

New York, NY 10004

COUNSEL FOR PLAINTIFF

KATHLEEN R. HARTNETT, ESQUIRE

ANDREW BARR, ESQUIRE

ELIZABETH REINHARDT, ESQUIRE

VALERIA M. PELE DEL TORO ESQUIRE

Cooley, LLP

3 Embarcadero Center, 20th Floor

San Francisco, CA 94111-4004

COUNSELS FOR PLAINTIFF

SRUTI SWAMINATHAN, ESQUIRE

Lambda Legal

120 Wall Street, 19th Floor

New York, NY 10005-3919

COUNSEL FOR PLAINTIFF

1 A P P E A R A N C E S (cont'd)

2

3 DAVID TRYON, ESQUIRE

4 State Capitol Complex

5 Building 1, Room E-26

6 Charleston, WV 25305

7 COUNSEL FOR STATE OF WEST VIRGINIA

8

9 ROBERTA F. GREEN, ESQUIRE

10 Shuman McCuskey Slicer, PLLC

11 1411 Virginia Street East

12 Suite 200

13 Charleston, WV 25301

14 COUNSEL FOR WEST VIRGINIA SECONDARY SCHOOL

15 ACTIVITIES COMMISSION

16

17 SUSAN DENIKER, ESQUIRE

18 Steptoe & Johnson

19 400 White Oaks Boulevard

20 Bridgeport, WV 26330

21 COUNSEL FOR HARRISON COUNTY BOARD OF EDUCATION and

22 HARRISON COUNTY SUPERINTENDENT DORA STUTLER

23

24

1 A P P E A R A N C E S (cont'd)

2

3 KELLY C. MORGAN, ESQUIRE

4 Bailey Wyant

5 500 Virginia Street East

6 Suite 600

7 Charleston, WV 25301

8 COUNSEL FOR WEST VIRGINIA BOARD OF EDUCATION and

9 SUPERINTENDANT W. CLAYTON BURCH

10

11 RACHEL CSUTOROS, ESQUIRE

12 Alliance Defending Freedom

13 15100 North 90th Street

14 Scottsdale, AZ 85260

15 COUNSEL FOR INTERVENOR, LAINEY ARMISTEAD

16

17 TRAVIS C. BARHAM, ESQUIRE

18 LAWRENCE WILKINSON, LAW CLERK

19 1000 Hurricane Shoals Road NE

20 Suite D 1100

21 Lawrenceville, GA 30043

22 COUNSEL FOR INTERVENOR, LAINEY ARMISTEAD

23

24

1	I N D E X	
2		
3	DISCUSSION AMONG PARTIES	11 - 13
4	<u>WITNESS</u> : ARON JANSSEN, M.D.	
5	EXAMINATION	
6	By Attorney Barham	13 - 295
7	EXAMINATION	
8	By Attorney Tryon	295 - 388
9	CERTIFICATE	390
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		

1	<u>EXHIBIT PAGE</u>		
2			
3			PAGE
4	<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>IDENTIFIED</u>
5	1	Expert Report	14
6	2	Endocrine Society's Guidelines	32
7	3	World Health Organization	35
8	4	Harvard Medical School Study	43
9	5	American Psychological Association	
10		Guidelines	48
11	6	Lisa Littman Study	53
12	7	Study	76
13	8	Article by Vandebussche	82
14	9	Article by Lily Durwood	84
15	10	Statement by Royal Australian and	
16		New Zealand College of	
17		Psychiatrists	97
18	11	Policy Change Regarding Hormonal	
19		Treatment of Minors	101
20	12	Article by Lisa Nainggolan	106
21	13	Study	107
22	14	Article Published on Medscape.com	108
23	15	Article in National Health Service	110
24	16	Article by Roberto D'Angelo	115

1	<u>EXHIBIT PAGE</u>		
2			
3	PAGE		
4	<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>IDENTIFIED</u>
5	17	Study by Gibson, et al.	126
6	18	Errata Sheet	130
7	19	Article by Tordoff, et al.	131
8	20	Article by Amy Green, et al.	133
9	21	Article by Turban, et al.	134
10	22	Article by Achille, et al.	135
11	23	Article by Kuper, et al.	137
12	24	Article by van der Miesen, et al.	138
13	25	Article by De Vries	140
14	26	Article by Biggs	142
15	27	Article by Costa, et al.	145
16	28	Article by Edwards-Leeper	148
17	29	Article by Edwards-Leeper	149
18	30	Interview by Lisa Selin Davis	176
19	31	Label of Lupron	218
20	32	Puberty Blockers Document	224
21	33	Endocrine Society's Guidelines	228
22	34	Article by Blakemore	232
23	35	Article by Guss, et al.	245
24	36	Article by Moseson, et al.	247

1	<u>EXHIBIT PAGE</u>		
2			
3			PAGE
4	<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>IDENTIFIED</u>
5	37	Article by Steensma	251
6	38	Analysis	251
7	39	Article by Rae, et al.	256
8	40	Article by Carmichael, et al.	262
9	41	<u>Washington Post</u> Article	268
10	42	<u>Out Sports</u> Article	271
11	43	Article by Turban, et al.	276
12	44	Article by Ryan, et al.	280
13	45	Article by Klein and Golub	281
14	46	Form	315
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			

OBJECTION PAGEATTORNEYPAGE

Block 17, 18, 19, 21, 22, 23, 24, 27, 29, 30, 31, 33,
34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 49, 50,
52, 54, 56, 57, 58, 59, 66, 68, 69, 70, 71, 72, 74, 75,
77, 78, 79, 80, 81, 82, 85, 86, 87, 88, 89, 91, 92, 95,
96, 97, 98, 99, 100, 101, 102, 104, 105, 106, 107, 109,
111, 113, 114, 115, 117, 118, 119, 120, 120, 121, 122,
123, 125, 129, 130, 132, 134, 138, 141, 142, 144, 145,
147, 153, 154, 156, 157, 158, 160, 161, 163, 165, 166,
167, 169, 172, 173, 174, 175, 177, 178, 179, 180, 181,
182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 193,
194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 206,
207, 208, 209, 210, 211, 213, 214, 217, 218, 219, 220,
221, 222, 223, 224, 226, 228, 229, 231, 234, 27, 238,
240, 241, 242, 243, 244, 245, 246, 247, 250, 254, 255,
258, 259, 260, 261, 264, 265, 266, 268, 269, 270, 272,
274, 275, 282, 284, 286, 288, 289, 290, 291, 292, 293,
294, 295, 298, 300, 301, 302, 303, 304, 308, 309, 310,
311, 312, 313, 314, 316, 317, 318, 319, 320, 321, 322,
323, 324, 325, 326, 327, 330, 331, 332, 333, 334, 336,
337, 337

S T I P U L A T I O N

(It is hereby stipulated and agreed by and between
counsel for the respective parties that reading,
signing, sealing, certification and filing are not
waived.)

P R O C E E D I N G S

ATTORNEY BARHAM: Counsel has stipulated
that our court reporter present this morning can swear
in the witness, so I will let the court reporter take
care of that.

ARON JANSSEN, M.D.,
CALLED AS A WITNESS IN THE FOLLOWING PROCEEDINGS, AND
HAVING FIRST BEEN DULY SWORN, TESTIFIED AND SAID AS
FOLLOWS:

VIDEOGRAPHER: My name is Jacob Stock.
I'm a Certified Legal Video Specialist employed by
Sargent's Court Reporting Services. The date today is
April 4th, 2022. The time on the video monitor reads
9:09 a.m. This deposition is being taken remotely by

1 Zoom conference. The caption is in the United States
2 District Court for the Southern District of West
3 Virginia, Charleston Division, BPJ, et al., versus West
4 Virginia State Board of Education, et al. Civil Action
5 Number 2:21-CV-00316. The name of the witness is Aron
6 Janssen. Will the attorneys present state their names
7 and the parties they represent?

8 ATTORNEY BARHAM: My name is Travis
9 Barham. I represent the intervenors in this case. And
10 with me is Lawrence Wilkinson.

11 ATTORNEY CSUTOROS: Rachel Csutoros also
12 for intervenor.

13 ATTORNEY TRYON: This is David Tryon of
14 the West Virginia Attorney General's Office,
15 representing the State of West Virginia.

16 ATTORNEY DENIKER: Good morning. Susan
17 Deniker. Counsel for Defendants Harrison County Board
18 of Education and Superintendent Dora Stutler.

19 ATTORNEY MORGAN: This is Kelly Morgan on
20 behalf of the West Virginia Board of Education and
21 Superintendent Burch.

22 ATTORNEY GREEN: This is Roberta Green
23 here on behalf of West Virginia Secondary School
24 Activities Commission.

1 ATTORNEY BLOCK: For Plaintiff BPJ, this
2 is Josh Block from the ACLU.

3 ATTORNEY SWAMINATHAN: This is Sruti
4 Swaminathan from Lambda Legal on behalf of Plaintiff.

5 ATTORNEY HARTNETT: Good morning. This
6 is Kathleen Hartnett at Cooley on behalf of Plaintiff.

7 ATTORNEY BARR: Andrew Barr from Cooley
8 on behalf of Plaintiff.

9 ATTORNEY PELET DEL TORO: Good morning.
10 This is Valeria Pelet Del Toro from Cooley on behalf of
11 Plaintiff.

12 ATTORNEY REINHARDT: This is Elizabeth
13 Reinhardt from Cooley on behalf of Plaintiff.

14 VIDEOGRAPHER: If that's everyone, the
15 witness has already been sworn in and we can begin.

16 ---

17 EXAMINATION

18 ---

19 BY ATTORNEY BARHAM:

20 Q. Good morning, Dr. Janssen.

21 A. Good morning.

22 Q. Have you ever had a deposition before?

23 A. No.

24 Q. All right.

1 I'm going to ask you a series of questions
2 about this case and your involvement in it. Do your
3 best to answer audibly. Just nodding the head, while it
4 can be captured on video cannot be captured by our court
5 reporter, and so we'll try to make her life as easy as
6 possible.

7 I'm going to do my best to wait until you finish
8 an answer before starting the next question. And I will
9 ask that you do the same. We'll probably violate that
10 rule a few times, but cross talk doesn't translate well
11 on the record. So if you need to take a break at any
12 time today, please let me know and we will do our best
13 to facilitate that as quickly as possible. I know we
14 need to take a break at two o'clock.

15 A. I think about 2:30, 2:45, something like that.

16 Q. Okay.

17 You just let us know when you need to take it.
18 All right.

19 ATTORNEY BARHAM: I'm going to show you a
20 document we're going to mark as Exhibit-1. This will be
21 Tab 90 for online purposes.

22 ---

23 (Whereupon, Exhibit 1, Expert Report, was
24 marked for identification.)

1 ---

2 BY ATTORNEY BARHAM:

3 Q. This is a copy of your expert report in this
4 case.

5 Is that correct?

6 A. Yes, that is correct.

7 Q. If you'll turn to the first page of your CV.
8 It's probably page 21 of this document. Do you
9 have ---?

10 VIDEOGRAPHER: This is the videographer.
11 Can I ask Counsel to speak up? You are kind of getting
12 cutoff at the end of your sentences.

13 ATTORNEY BARHAM: Pardon. I will do my
14 best.

15 BY ATTORNEY BARHAM:

16 Q. Do you have a degree in adult psychiatry?

17 A. There is not a degree in psychiatry.

18 Q. Okay.

19 So your academic training in psychiatry began
20 with your psychiatry residency? Is that how it works?

21 A. I did a medical degree, where there is
22 psychiatry training and then a residency in adult
23 psychiatry and a fellowship in child psychiatry.

24 Q. Do you consider yourself trained and

1 professionally competent in using the American
2 Psychiatric Association's Diagnostic and Statistical
3 Manual, DSM-V, to make child and adolescent mental
4 illness or psychiatric diagnoses generally beyond just
5 gender dysphoria?

6 A. Yes.

7 Q. Do you have any residency or fellowship in
8 pediatrics?

9 A. No.

10 Q. Do you have any residency or fellowship in
11 endocrinology?

12 A. No.

13 Q. Do you have any training in sports physiology?

14 A. No.

15 Q. Do you have any training in sports medicine?

16 A. No.

17 Q. Have you published any papers, conducted any
18 research or given any lectures relating to sports
19 physiology?

20 A. No.

21 Q. Have you published any papers, conducted any
22 research or given any lectures relating to sports
23 medicine?

24 A. No.

1 Q. Have you published any papers, conducted any
2 research or given any lectures relating to male
3 physiological advantages in athletics before, during or
4 after puberty?

5 A. No.

6 ATTORNEY BLOCK: Objection to form. You
7 can answer.

8 BY ATTORNEY BARHAM:

9 Q. Have you published any papers, conducted any
10 research or given any lectures relating to the impact of
11 any drugs or hormones on athletic performance?

12 A. No.

13 Q. Have you published any papers, conducted any
14 research or given any lectures relating to the impact of
15 testosterone suppression on athletic performance?

16 A. No.

17 Q. Have you published any papers, conducted any
18 research or given any lectures relating to the effect of
19 transsex surgeries on athletic performance?

20 A. No.

21 ATTORNEY BLOCK: Objection. Objection to
22 terminology.

23 BY ATTORNEY BARHAM:

24 Q. Have you published any papers, conducted any

1 research or given any lectures relating to the safety
2 issues and risks to women associated with transgender
3 participation in female athletics by male athletes?

4 ATTORNEY BLOCK: Objection to form.
5 Sorry, objection to form.

6 THE WITNESS: Yeah, I think there's a bit
7 of a premise in there that I don't agree with, but I
8 have not given any lectures about transgender
9 participation in sports.

10 BY ATTORNEY BARHAM:

11 Q. Do you consider --- do you have any professional
12 expertise related to the concept of fairness?

13 A. I do not.

14 Q. Do you have any professional expertise on the
15 definition of fairness?

16 A. I do not.

17 Q. Would you agree that fairness is an elusive,
18 subjective concept with malleable boundaries?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: I do not have an opinion on
21 the definition of fairness.

22 BY ATTORNEY BARHAM:

23 Q. Have you treated or personally examined BPJ?

24 A. I have not.

1 Q. You have no direct knowledge as to what Tanner
2 stage BPJ started puberty blockers at the age.

3 Correct?

4 A. Correct.

5 Q. You do not know how BPJ's physiology or athletic
6 capabilities compare with genetic females at the same
7 age?

8 A. I do not.

9 ATTORNEY BLOCK: Objection to
10 terminology.

11 BY ATTORNEY BARHAM:

12 Q. This report, Exhibit-1 of 20 pages sets out the
13 complete statement of all opinions that you will testify
14 to at trial.

15 Correct?

16 A. Which report are you referring to?

17 Q. The report in front of you, Exhibit-1, Tab 90.

18 A. And can you repeat the question? Sorry.

19 Q. This report sets out a complete statement of all
20 opinions that you will testify to at trial.

21 Correct?

22 A. I do not know the answer to that. I mean, I
23 would assume so, but I don't know. I've never been in a
24 trial, so I don't know if there will be questions asked

1 outside of this document.

2 Q. Does this report identify all facts and data
3 that you considered in forming the opinions that you set
4 forth in your report?

5 A. I wouldn't say it has all facts because I don't
6 think it is possible to include all facts in an expert
7 report, but the relevant facts, yes.

8 Q. This includes the facts that you'll rely on in
9 supporting those opinions.

10 Correct?

11 A. That's correct.

12 Q. Does your report set out all the reasons for the
13 opinions that you propose to offer?

14 A. Yes.

15 Q. Your footnotes cite to I believe 32 scientific
16 or professional articles and you reference some others
17 in your CV. Are those all the articles that form the
18 basis of the opinions you propose to offer?

19 A. No.

20 Q. What other articles form the basis of the
21 opinions you propose to offer?

22 A. I guess the question is what has formed my
23 professional expertise around gender health, and I've
24 read a lot that aren't necessarily going to be apropos

1 to this specific report.

2 Q. But those are the articles that you cited and
3 referenced in this document are those that you relied
4 upon as the basis of opinions that you intend to offer.

5 Correct?

6 A. That is correct.

7 Q. You currently serve as the Clinical Associate
8 Professor of Child and Adolescent Psychiatry.

9 Correct?

10 A. Yes.

11 Q. And what institution is that with?

12 A. It is with Northwestern University Feinberg
13 School of Medicine, and Ann and Robert H. Lurie
14 Children's Hospital of Chicago.

15 Q. And how much of your time in this position is
16 related to discussing or treating gender dysphoric
17 children and adolescents?

18 ATTORNEY BLOCK: Objection to
19 terminology.

20 THE WITNESS: It's hard to quantify.
21 Probably about 40 percent of my time is allocated in
22 some way to either clinical care, research or academics
23 around gender health.

24 BY ATTORNEY BARHAM:

1 Q. And what is your compensation for this position?

2 A. It is roughly \$265,000 a year in salary.

3 Q. You also serve as the Vice Chair of the
4 Pritzker Department of Psychology and Behavioral Health
5 at the Ann and Robert H. Lurie Children's Hospital of
6 Chicago.

7 Correct?

8 A. That's correct.

9 Q. And how much of your time in this position is
10 related to discussing or treating gender dysphoric
11 children and adolescents?

12 ATTORNEY BLOCK: Objection to
13 terminology.

14 THE WITNESS: Again, it is hard to parse
15 out what specific about my leadership role is around
16 gender health but it is a minority of my day-to-day
17 work in that role.

18 BY ATTORNEY BARHAM:

19 Q. Do you have an approximate percentage?

20 A. No.

21 Q. Twenty-five (25) percent, more or less?

22 A. Probably ten percent.

23 Q. Ten percent. Okay.

24 And what is your compensation for that

1 position?

2 A. I get a stipend of around \$30,000.

3 Q. You currently serve as the Medical Director of
4 Outpatient Psychiatric Services at the Lurie Children's
5 Hospital of Chicago.

6 Is that correct?

7 A. That's correct.

8 Q. And how much of your time in this position is
9 related to discussing or treating gender dysphoric
10 children and adolescents?

11 ATTORNEY BLOCK: Objection to
12 terminology.

13 THE WITNESS: About 25 percent of my time
14 is probably spent discussing or related to the health of
15 transgender youth or transgender --- gender diverse
16 youth.

17 BY ATTORNEY BARHAM:

18 Q. And what is your compensation for that position?

19 A. There is no compensation.

20 Q. You currently serve as the Clinical Director of
21 the NYU Gender and Sexuality Services.

22 Is that correct?

23 A. That is not correct.

24 Q. When did you conclude your role in that

1 position? I'm referencing page one of your CV.

2 A. That was when I moved to Chicago a few years
3 ago.

4 Q. Okay.

5 So where it says 2011 to present Clinical
6 Director, NYU Sexuality Service, that is just a typo?

7 A. That is a typo, yes.

8 Q. You currently serve as the Associate Professor
9 of Child and Adolescent Psychology at Northwestern
10 University, and we have already discussed that. Is
11 there a difference between Clinical Associate Professor
12 and Associate Professor of Child and Adolescent
13 Psychiatry?

14 A. No.

15 Q. You serve as the Vice Chair of Clinical Affairs
16 at the Pritzker Department of Psychiatry and Behavioral
17 Health at the Lurie Children's Hospital.

18 Correct?

19 A. That's correct.

20 Q. And how much time in this position is related to
21 discussing or treating gender dysphoric children and
22 adolescents?

23 ATTORNEY BLOCK: Objection to
24 terminology.

1 THE WITNESS: I think I answered that one
2 with the guess of about ten percent.

3 BY ATTORNEY BARHAM:

4 Q. Okay?

5 So that's the same as the Vice Chair of the
6 Department of Psychiatry?

7 A. Correct.

8 Q. You currently serve as the Associate Editor for
9 Transgender Health.

10 Correct?

11 A. That is correct.

12 Q. And what is your compensation for that position?

13 A. There is no compensation for that position.

14 Q. What is that publication's annual income?

15 A. I do not know.

16 Q. You serve as a reviewer for LGBT Health.

17 Correct?

18 A. Yes.

19 Q. And how much of your time is related --- in that
20 position is related to treating or discussing
21 transgender children and adolescents?

22 A. I would say 100 percent of my review time with
23 LGBT health is around gender.

24 Q. Do you receive any compensation for that

1 position?

2 A. I do not.

3 Q. Do you receive any compensation for your role as
4 a reviewer with the Journal of the Academy of Child and
5 Adolescent Psychiatry?

6 A. I do not.

7 Q. You served in various positions with different
8 professional organizations according to paragraphs 11
9 and 12 of your report. Do any of those positions
10 provide you financial compensation?

11 A. No.

12 Q. You founded and directed Gender Variant Youth
13 and Family Network.

14 Correct?

15 A. Correct.

16 Q. What's your compensation for that position?

17 A. Zero.

18 Q. What is the entity's annual income or budget?

19 A. Zero.

20 Q. You indicate in your report that you have seen
21 approximately 500 transgender patients.

22 Is that correct?

23 A. That is correct.

24 Q. How many patients do you see per year?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: I'd have to look at my
3 report. I don't have the information in front of me
4 right now.

5 BY ATTORNEY BARHAM:

6 Q. Do you have a ballpark of how many patients you
7 see in a year?

8 A. I don't.

9 Q. Does this include --- and I'm assuming that your
10 colleagues see additional patients beyond just those
11 that you see.

12 Correct?

13 A. Correct.

14 Q. How frequently do you see each patients?

15 A. I see --- the frequency with which I see
16 patients is dependent upon their clinical need, so
17 between once or twice a week to once every three months.

18 Q. And how much are patients charged per
19 appointment?

20 A. Everything is billed to their insurance, so I'm
21 not sure.

22 Q. Do you receive any other income related to your
23 work on gender dysphoria?

24 A. I'm being paid for my expert report for this, so

1 that's the only other income I receive.

2 Q. Do you receive any speaking fees?

3 A. I have received speaking fees for participation
4 and grand rounds as an example.

5 Q. And how much would those speaking fees run?

6 A. It is typically about a thousand dollars per
7 event.

8 Q. Before the last four years had you provided any
9 expert testimony on issues related to gender dysphoria?

10 A. Can you clarify the difference between
11 testimonies and reports? I've submitted a report but
12 not ---.

13 Q. Okay.

14 So you have submitted a report?

15 A. Correct.

16 Q. Do you remember what case that involved?

17 A. That involves Medicaid and top surgery in
18 Arizona.

19 Q. Okay.

20 Have you ever provided any testimony in trial
21 or deposition before related to gender dysphoria?

22 A. I have not.

23 Q. And how much compensation have you received so
24 far in this case?

1 A. This case so far, none thus far.

2 Q. How much are you expecting to receive so far in
3 this case?

4 A. I haven't added up my invoice yet, but I imagine
5 it's probably around \$10,000.

6 Q. Okay.

7 Do you have any professional expertise related
8 to the legal definition of relevance?

9 A. I do not.

10 Q. Do you have any legal training or education?

11 A. I do not.

12 Q. When you were preparing your report did you
13 consult the Federal Rules of Evidence or any other legal
14 sources as to the meaning of relevance?

15 A. I did not.

16 Q. Several people in this case have referenced
17 disorders of sexual development. Would you agree that
18 gender dysphoria is not a disorder of sexual
19 development?

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: Gender dysphoria has not
22 been classified as a disorder of sexual development.

23 BY ATTORNEY BARHAM:

24 Q. Of the approximately 500 transgender patients

1 you had seen how many suffered from disorder of sexual
2 development?

3 A. A minority of patients, less than ten.

4 Q. So you would agree that the vast majority of
5 individuals with gender dysphoria or who assert a
6 transgender identity do not suffer from a disorder of
7 sexual development.

8 Correct?

9 ATTORNEY BLOCK: Objection to form.

10 THE WITNESS: The data we have speaks to
11 the majority of people with gender dysphoria do not have
12 a disorder of sex development.

13 BY ATTORNEY BARHAM:

14 Q. Do you have any reason to believe that BPJ
15 suffers from a disorder of sexual development?

16 A. I have not reviewed BPJ's case.

17 Q. Are you aware of any instance in which an
18 individual with a disorder of sexual development has
19 attempted to play on a girls' or women's sports team in
20 West Virginia?

21 A. I am not aware.

22 Q. Is it your opinion that a person's gender
23 identity is durable?

24 ATTORNEY BLOCK: Objection to form.

1 THE WITNESS: Can you define durable?

2 BY ATTORNEY BARHAM:

3 Q. Unchanging.

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: It is my testimony that
6 there is a concept of gender identity that remains
7 generally fixed for most people throughout their lives.

8 BY ATTORNEY BARHAM:

9 Q. So it's your opinion that a person's gender
10 identity cannot be changed with medical or mental health
11 intervention.

12 Correct?

13 COURT REPORTER: Sorry, Counsel, that
14 question one more time.

15 BY ATTORNEY BARHAM:

16 Q. So it's your opinion that a person's gender
17 identity cannot be changed with medical or mental health
18 intervention.

19 Correct?

20 A. Yes.

21 ATTORNEY BARHAM: I'm going to hand you
22 what we're going to mark as Exhibit-2. This will be
23 Tab 5.

24 ---

1 (Whereupon, Exhibit-2, Endocrine
2 Society's Guidelines, was marked for
3 identification.)

4 ---

5 BY ATTORNEY BARHAM:

6 Q. If you'll turn to page 3873 of this document.
7 This document is the Endocrine Society's Guidelines,
8 Endocrine Treatment of Gender Dysphoric or Gender
9 Incongruent Persons, Endocrine Society Clinical Practice
10 Guideline published in 2017.

11 Correct?

12 A. That is correct.

13 Q. On page 3873 of this document the Endocrine
14 Society indicates that this continuum gender identity
15 ranged from all male through something in between to all
16 female yet such a classification does not take into
17 account that people may have gender identities outside
18 this continuum. For instance, some experience
19 themselves as having both a male and female gender
20 identity whereas others completely renounce any gender
21 classification. There are also reports of individuals
22 experiencing a continuous and rapid involuntary
23 alternation between a male and female identity.

24 Do you see that?

1 A. I don't see that.

2 Q. Second column, towards the bottom of the page.

3 A. Yes, I see that.

4 Q. Is this consistent with your understanding of
5 gender identity?

6 ATTORNEY BLOCK: Can you give him time to
7 read?

8 ATTORNEY BARHAM: Gladly.

9 THE WITNESS: I think there is a
10 difference between a gender identity and how people
11 understand and express that gender identity. And in the
12 context of this article the rapid involuntary alteration
13 between male and female identity as an example is a case
14 reported of single individuals subjective experience of
15 their gender according to the reference.

16 BY ATTORNEY BARHAM:

17 Q. And by that you're referring to note ten?

18 A. Correct.

19 Q. So according to this document, someone can be
20 one sex or the other, both, neither or in between.

21 Correct?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: I can't speak for the
24 conclusions drawn by the author of this article.

1 BY ATTORNEY BARHAM:

2 Q. And according to the Endocrine Society a
3 person's gender identity can change rapidly.

4 Correct?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: I'm not a part of the
7 Endocrine Society, so I'm not sure how they discuss
8 this.

9 BY ATTORNEY BARHAM:

10 Q. According to this document, the Endocrine
11 Society is indicating that there are reports, plural, of
12 individuals, plural, experiencing a continuous and rapid
13 involuntary alternation between male and female gender
14 identity.

15 Correct?

16 A. That is documented in the article.

17 Q. Okay.

18 A. I'm not sure of the governance of the Endocrine
19 Society.

20 Q. Do you think the Endocrine Society Guidelines
21 are wrong?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: I think anything relating
24 to gender identity has to be taken in a broader context

1 within both the article in and of itself but in broader
2 practice and specifically around children and
3 adolescents.

4 BY ATTORNEY BARHAM:

5 Q. So what is your basis for indicating that this
6 statement is potentially inaccurate?

7 ATTORNEY BLOCK: Objection to form.

8 THE WITNESS: I think there is more
9 context that's needed in order to understand the intent
10 of the authors in this particular section.

11 ATTORNEY BARHAM: I'm going to hand you
12 what we will mark as Exhibit-3. This is the document
13 from the World Health Organization entitled Gender and
14 Health.

15 ---
16 (Whereupon, Exhibit-3, World Health
17 Organization, was marked for
18 identification.)

19 ---

20 BY ATTORNEY BARHAM:

21 Q. Are you familiar with the World Health
22 Organization?

23 A. I've heard of them.

24 Q. Do you agree with these World Health

1 Organization statements?

2 ATTORNEY BLOCK: Objection to form. Can
3 he have time to read the document?

4 ATTORNEY BARHAM: Of course.

5 VIDEOGRAPHER: Counsel, is that Tab 10?

6 LAW CLERK WILKINSON: Tab 10.

7 ATTORNEY BARHAM: It is.

8 VIDEOGRAPHER: Okay. Thank you.

9 THE WITNESS: Can you repeat the
10 question?

11 BY ATTORNEY BARHAM:

12 Q. Do you agree with these World Health
13 Organization statements?

14 A. Not in their entirety.

15 Q. In what parts do you dispute?

16 A. The word gender as a concept is much more
17 complicated and I do not agree with their
18 characterization in this page.

19 Q. So the World Health Organization says that
20 gender itself is a social construct and can change over
21 time.

22 Correct?

23 ATTORNEY BLOCK: Objection to form. Does
24 this document have a URL to it?

1 ATTORNEY BARHAM: It does, but I don't
2 see it printed on the document.

3 LAW CLERK WILKINSON: We can get it.

4 ATTORNEY BARHAM: We can supply that.

5 THE WITNESS: I agree that it says on the
6 document that gender varies from society to society and
7 can change over time.

8 BY ATTORNEY BARHAM:

9 Q. And according to the World Health Organization,
10 gender identity refers to a person's experience of
11 gender which is a social construct.

12 Correct?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: I don't see in the document
15 where it refers to gender identity or defines gender
16 identity.

17 BY ATTORNEY BARHAM:

18 Q. It says gender interacts with different sex,
19 which refers to the different biological and
20 physiological characteristics of males, females,
21 intersex persons such as chromosomes, hormones and
22 reproductive organs.

23 Correct?

24 A. That is correctly read. I don't see gender

1 identity defined in this document.

2 Q. Gender identity refers to a person's deeply held
3 internal and individual experience of gender.

4 Correct?

5 A. That's what it says here, yes.

6 Q. If an individual asserts an identity of man or
7 both, how can a clinician verify whether that individual
8 is telling the truth?

9 ATTORNEY BLOCK: Objection to form.

10 THE WITNESS: I'm not sure what exactly
11 that means. The process of an assessment for gender
12 care involves a complex series of interviews,
13 diagnostics.

14 BY ATTORNEY BARHAM:

15 Q. So how does the clinician assess whether the
16 patient is accurately relating their experiences?

17 A. In the typical process, particularly around
18 child and adolescent psychiatry, part of the assessment
19 involves information gathered from multiple contexts.

20 Q. Such as?

21 A. Such as parents, schools, caregivers, other
22 providers, history over time, et cetera.

23 Q. And if --- so how does one assess from those
24 various contexts whether someone who's claiming to be

1 male or both is accurately relating what's going on?

2 ATTORNEY BLOCK: Objection to form.

3 THE WITNESS: Yeah, I guess I don't
4 understand the question exactly. You know, my job is
5 not necessarily to define what is accurate in someone's
6 own experience. It's to understand how that fits into
7 typical processes and developmental expectations for the
8 broad range of gender diversity over time.

9 BY ATTORNEY BARHAM:

10 Q. How do you determine whether someone in that
11 scenario is accurately understanding his own subjective
12 feelings --- his or her subjective feelings?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: The context of the
15 treatment is really important. If an individual is
16 seeking specific interventions that require a mental
17 health assessment, there are specific components of that
18 mental health assessment that must be met.

19 BY ATTORNEY BARHAM:

20 Q. So what are the treatments that would require a
21 mental health assessment?

22 A. Puberty blocking medications, hormones or
23 surgery.

24 Q. And what are the interventions that would not

1 require mental health evaluations, in your opinion?

2 ATTORNEY BLOCK: Objection to form.

3 THE WITNESS: It depends upon what
4 guidelines you're talking about and what recommendations
5 that the family is looking for.

6 BY ATTORNEY BARHAM:

7 Q. Well, what are some of the inventions? You said
8 there's some interventions that would require a mental
9 health evaluation, so that implies that there are some
10 that would not. What are the interventions that would
11 not require a mental health evaluation?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: You know, parents giving
14 hugs to their kids is not something that a mental health
15 assessment would require. Providing a way of helping
16 families to understand their kids or asking questions is
17 not something that requires a mental health evaluation
18 and some children will socially transition prior to any
19 assessments by any mental health professional.

20 BY ATTORNEY BARHAM:

21 Q. How do you determine --- if an individual
22 asserts a gender identity of male or both, how do you
23 determine whether the individual is making a statement
24 based on societal expectations for a particular gender

1 rather than ---?

2 ATTORNEY BLOCK: Objection. Travis, I'm
3 sorry, the male or both phrasing, is that a quote from
4 something. I don't have the paper in front of me, so
5 just want to clarify.

6 ATTORNEY BARHAM: No, that's not a
7 question from something. That's just my question.

8 ATTORNEY BLOCK: Okay.

9 THE WITNESS: Can you repeat the
10 question?

11 BY ATTORNEY BARHAM:

12 Q. If an individual asserts a gender identity male
13 or both, how can a clinician verify whether the
14 individual is making the statement based on societal
15 expectations for a particular gender rather than his own
16 genuine gender?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: I personally never had
19 anybody assert an identity of male or both, but part of
20 the assessment of --- if we are diagnosing gender
21 dysphoria is understanding the cultural and social
22 contexts and ensuring that folks are not presenting with
23 a gender identity that is incongruent with their sex
24 assigned at birth because of actual or perceived

1 cultural advantages.

2 BY ATTORNEY BARHAM:

3 Q. And how does one go about assessing the
4 motivations behind the claimed gender identity or
5 transgender sex?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: For any psychiatric
8 assessment this is through a combination of interviews,
9 gathering history from relevant data sources and
10 sometimes for some people structured interviews or
11 scales.

12 BY ATTORNEY BARHAM:

13 Q. And how long does it take to conduct such an
14 assessment?

15 A. There is no specific timeframe involved in this
16 assessment. It really depends upon contextual factors
17 that are hard to nail down.

18 Q. So if you were treating a child or teenager, how
19 many relevant data sources would you need to get
20 information from in order to make a complete assessment
21 of the child's motivations?

22 A. I don't think there's ever going to be a
23 concrete answer in terms of how many. There's not a
24 specific answer of how many sources are necessary. It's

```
1 | however many sources are necessary to gather the
2 | relevant information.
```

3 Q. So how do you determine whether you have
4 gathered enough information to make a competent
5 assessment?

6 A. It's hard to state this in a non-pithy way, but
7 that's kind of what the process of psychiatry and child
8 psychiatry training helps you to learn.

9 Q. Could you explain to someone who doesn't have
10 the training how you come to the conclusion, okay, I've
11 gathered enough information to make a competent
12 assessment?

13 A. Sure. I can try. How accurate is the reporter
14 in their description of their history. How much does it
15 align with reports from other informants, how much does
16 it match with or is deviant from expected phenotypic
17 processes with the disorders in question and what is the
18 impression of the evaluator about the accuracy of the
19 statements.

20 ATTORNEY BARHAM: I'm going to show you
21 what we will mark as Exhibit-4, this will be Tab 12.

22 | ---

23 (Whereupon, Exhibit-4, Harvard Medical
24 School Study, was marked for

1 identification.)

2 ---

3 BY ATTORNEY BARHAM:

4 Q. Are you familiar with this study? This is a
5 study from the Harvard Medical School entitled Gender
6 Fluidity: What it Means and Why Support Matters?

7 ATTORNEY BLOCK: Objection.

8 THE WITNESS: This looks like a popular
9 website article and not a study.

10 BY ATTORNEY BARHAM:

11 Q. Are you familiar with the author, Dr. Sabrina
12 Katz --- Sabra Katz-Wise?

13 A. Dr. Katz-Wise has published in the world of
14 transgender health. I'm not familiar with them
15 personally, I don't know them.

16 Q. Do you know Dr. Katz-Wise at least by
17 reputation?

18 A. I don't. I've only read some studies.

19 Q. But you would agree that she is highly respected
20 in this area.

21 Correct?

22 A. I would not be able to offer an opinion.

23 Q. But she is widely published in this area.

24 Correct?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: From my recollection, yes.

3 BY ATTORNEY BARHAM:

4 Q. At the bottom of page two of this document, Dr.
5 Katz-Wise indicates that while some people develop a
6 gender identity early in childhood others may identify
7 with one gender at one time and then another gender
8 later on.

9 Is that correct?

10 A. You're reading that accurately, yeah.

11 Q. So according to this article, on page three a
12 gender fluid person is one whose gender identity changes
13 frequently.

14 Correct?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: I do not --- I have not
17 read it in here that it is defined in that way and
18 that's not how I would define gender fluidity.

19 BY ATTORNEY BARHAM:

20 Q. At least you see the statement at the first full
21 paragraph at the top of page three, ultimately anyone
22 who identifies as gender fluid, is a gender fluid person
23 often the term is used for a person's gender expression
24 or gender identity, essentially their internal sense of

1 self changes frequently?

2 ATTORNEY BLOCK: Objection. We're
3 jumping quickly from pages. Can you give him some more
4 time to read before answering the question?

5 ATTORNEY BARHAM: Certainly.

6 THE WITNESS: Yes. I'm not seeing where
7 that is here. Can you point that out for me?

8 BY ATTORNEY BARHAM:

9 Q. Top of page three, just above that, how is
10 gender fluidity related to health in child and teens?

11 A. Gender fluidity is a very nonspecific term that
12 means very different things to different people. In the
13 practice of the clinical work with transgender and
14 gender diverse youth, kids who are self identifying as
15 gender fluid, I want to understand what it means to them
16 and what that definition is for that individual. I
17 don't think there is one established definition of
18 gender fluidity that has been agreed upon.

19 Q. But at least some respected professionals in
20 this arena indicate that the term gender fluidity means
21 that the person's internal sense of self, their gender
22 identity changes frequently.

23 Correct?

24 ATTORNEY BLOCK: Objection to form.

1 THE WITNESS: I can't speak to what Dr.
2 Katz-Wise is using to define it. The way I would
3 describe gender fluidity, again outside the context of
4 how my patients are actually using the term, is that
5 understanding of the expression of gender identity may
6 change over time.

7 BY ATTORNEY BARHAM:

8 Q. So you said that their understanding of gender
9 identity can change over time. Dr. Katz-Wise says that
10 their gender identity changes frequently?

11 Is that correct?

12 A. That's what it stated in this popular press
13 article.

14 Q. And Dr. Katz-Wise is an Assistant Professor in
15 Adolescent and Young Adult Medicine at Boston Children's
16 Hospital.

17 Is that correct?

18 A. I would have to take your word for that.

19 Q. Okay.

20 Are you aware that she co-directs the Harvard
21 Sexual Orientation and Gender Identity Expression Equity
22 Research Collaborative?

23 A. I do not know the term, no.

24 ATTORNEY BARHAM: I'm going to show you

1 what we will mark as Exhibit-5, and this will be Tab 13.

2 ---

3 (Whereupon, Exhibit-5, American
4 Psychological Association Guidelines,
5 was marked for identification.)

6 ---

7 BY ATTORNEY BARHAM:

8 Q. This document is the American Psychological
9 Association Guidelines for Psychological Practice with
10 Transgender and Gender Non-Conforming People.

11 Correct?

12 A. That is correct.

13 Q. And on page 836 of this document the APA writes
14 just as some people experience their sexual orientation
15 as being fluid or variable, some people also experience
16 their the gender identity as fluid.

17 Correct?

18 A. Can you show me on the page where that is?

19 Q. The bottom of the first paragraph in the first
20 column of page 836.

21 A. Yes.

22 Q. So the APA Guidelines say that gender identity
23 can be fluid or changing.

24 Correct?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: Well, I think the important
3 piece is some people experience gender identity as fluid
4 or variable.

5 BY ATTORNEY BARHAM:

6 Q. So it can be fluid or changing?

7 Correct?

8 ATTORNEY BLOCK: Objection to form.

9 BY ATTORNEY BARHAM:

10 Q. For at least some people.

11 Correct?

12 THE WITNESS: As I would describe it and
13 understand it, that's the experience of expression of
14 gender identity can be fluid over time, which is
15 different.

16 BY ATTORNEY BARHAM:

17 Q. How is that different to say that one's gender
18 identity changes?

19 A. It's getting a little complicated in terms of
20 the concepts that we're talking about, but the identity
21 that gender identity is something that is inherently
22 fixed, that how people understand, experience it and
23 express it can change over time. That's the difference.

24 Q. But the American Psychological Association at

1 least describes gender identity as being fluid.

2 Correct?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: In the article that you
5 have put in front of me it describes that people's
6 experience of their gender identity is fluid over time.

7 BY ATTORNEY BARHAM:

8 Q. Let's go back to Tab 5, which is Exhibit-2. Are
9 you familiar with the Endocrine Society Guidelines?

10 A. I am.

11 Q. Is it your view that these guidelines were
12 developed through rigorous scientific processes?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: I agree.

15 BY ATTORNEY BARHAM:

16 Q. Would you agree that these guidelines were
17 developed by among the most respected researchers in the
18 field?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: I wouldn't disagree with
21 that, no.

22 BY ATTORNEY BARHAM:

23 Q. Do you respect Dr. Hembree of Columbia
24 University Medical Center?

1 A. I do.

2 Q. Do you respect Dr. Cohen-Kettenis of the
3 University of Amsterdam?

4 A. I would say I respect all of these clinicians
5 and researchers, although Sabine Hannema I am not
6 familiar personally.

7 Q. If you will turn to page 3879 of this document.
8 Right under the heading evidence this article reports
9 that the large majority, about 85 percent of prepubertal
10 children with a childhood diagnosis did not remain GD,
11 slash, gender incongruent in adolescence.

12 Is that correct?

13 A. That is correctly read, yes.

14 Q. And footnote 20 of this document cites to Dr.
15 Steensma, de Vries, Cohen-Kettenis article in 2013?

16 A. That's correct.

17 Q. These are extensively published original peer
18 reviewed research --- peer reviewed researchers in the
19 field.

20 Correct?

21 A. Correct.

22 Q. So this committee reveals evidence that the
23 large majority of children, about 85 percent, with a
24 childhood diagnosis do not remain gender dysphoric in

1 gender adolescence.

2 Correct?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: Yeah, in these studies have
5 been published primarily by the Dutch clinic the rates
6 of dissentience of the diagnosis of gender dysphoria has
7 been upwards of 85 percent.

8 BY ATTORNEY BARHAM:

9 Q. And at the bottom of the first column of
10 page 3879 the committee indicates that their clinical
11 experience suggests that the persistence of gender
12 dysphoria or gender incongruence can only be reliably
13 assessed after the first signs of puberty.

14 Is that correct?

15 A. That is what is written, yes.

16 Q. You have not offered an opinion in your report
17 as to whether or --- whether or to what transgender
18 identity has a biological basis.

19 Is that correct?

20 A. Let me just make sure that I'm reviewing it. I
21 have not offered an opinion.

22 Q. If you will turn to page 76 of Exhibit-2, Tab 5.
23 The committee with all of its experience and presenting
24 all the evidence said that gender dysphoria in children,

1 quote, does not invariably persist into adolescence and
2 adulthood.

3 Is that correct?

4 A. That is correct.

5 Q. In fact, this committee concluded that that
6 gender dysphoria, a minority of prepubertal children
7 appears to persist in adolescence.

8 Is that correct?

9 A. That is correct.

10 Q. I'm going to turn your attention to --- this
11 will be Tab 15, Exhibit-6.

12 ---

13 (Whereupon, Exhibit-6, Lisa Littman
14 Study, was marked for identification.)

15 ---

16 BY ATTORNEY BARHAM:

17 Q. This is a 2021 study by Lisa Littman entitled
18 Individuals Treated for Gender Dysphoria with a Medical
19 and/or Surgical Transition who Subsequently
20 De-transitioned.

21 Is that correct?

22 A. That is correct.

23 Q. Are you familiar with this study?

24 A. I am.

1 Q. The study was based on survey responses from a
2 hundred adult individuals who were approved for hormonal
3 and/or surgical transition, underwent such transition,
4 lived in a transgender identity for a period of years
5 and then decided to de-transition or revert to a gender
6 identity associated with their biological sex.

7 Is that correct?

8 A. That is my understanding of the study, yes.

9 Q. And all of the subjects had detransitioned by
10 discontinuing their medications, having surgeries to
11 reverse the effects of transition or both.

12 Correct?

13 ATTORNEY BLOCK: Objection to form. Are
14 you reading something?

15 ATTORNEY BARHAM: I'm referencing
16 page two, column two, at the bottom of the page.

17 THE WITNESS: My recollection from the
18 study was that this was all self report, so there was no
19 way to verify if that was correct or true.

20 BY ATTORNEY BARHAM:

21 Q. But that's at least what the participants
22 reported.

23 Correct?

24 A. From my recollection. I'd have to reread the

1 entire study to say for sure but that is my
2 recollection, yes.

3 Q. And if you turn to page eight of the second
4 column, under the heading de-transition?

5 A. I don't have page numbers on mine.

6 ATTORNEY BLOCK: Do you reference the
7 page number at the top?

8 ATTORNEY BARHAM: The source contains no
9 page numbers, making it difficult.

10 BY ATTORNEY BARHAM:

11 Q. Under the heading detransition it's the page
12 right before table four.

13 ATTORNEY BLOCK: I'm sorry. Can I see
14 the heading on the document? Just for the record, this
15 doesn't appear to be a paginated version of the article
16 where, you know, when I pull it up I get a publication,
17 date and pages. So I don't know if this is the final
18 version of the article or not, but you can proceed with
19 the questions.

20 ATTORNEY BARHAM: Counsel, I'll return to
21 your concerns, Mr. Block.

22 BY ATTORNEY BARHAM:

23 Q. Do you see the one page before the page that
24 contains Table 4?

1 A. I do.

2 Q. Do you see the heading detransition?

3 A. I do.

4 Q. And it says there that when participants decided
5 to detransition they were a mean age of 26.4 years old.

6 Correct?

7 A. That is correct.

8 Q. Have you read this study before today?

9 A. I have.

10 Q. So doesn't this study at least suggest that
11 patients may think they have a sense of belonging to the
12 opposite sex but can be mistaken?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: I think what this study
15 does is hear experiences from a select group of
16 individuals who are motivated to participate in the
17 study about detransition and hear their experiences of
18 their care.

19 BY ATTORNEY BARHAM:

20 Q. But the study still indicates that those
21 individuals had a sense of belonging to the opposite sex
22 and later concluded that they were were mistaken.

23 Is that correct?

24 A. You will have to forgive my clinician nature

1 here, but language is important when working with
2 patients who are transitioning. I don't know if that's
3 the language that they would use or if that is the
4 language that was used in this particular survey.

5 Q. But the effect of detransitioning is that they
6 at one time thought they belonged to the opposite sex
7 and then later concluded that they did not?

8 ATTORNEY BLOCK: Objection to the form.

9 THE WITNESS: Again, I think we would
10 want to know specifically what each individual person,
11 how they described their process. I don't know what
12 detransition means to those who are taking a relatively
13 anonymous survey, so it's hard to draw a conclusion
14 about the specific nature of it. The generally accepted
15 upon definition of detransition is generally aligned
16 with somebody who reverts back to a gender identity or
17 gender expression that is more aligned with their sex
18 assigned at birth.

19 BY ATTORNEY BARHAM:

20 Q. This study defines detransition as discontinuing
21 medications, having surgeries to reverse the effect of
22 transition or both.

23 Is that correct? It is on page two?

24 A. Show me where on page two.

1 Q. The second column of page two, at the bottom of
2 the page?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: Yeah. I'm not seeing that
5 Dr. Littman is specifically defining detransition but
6 describing the objective of the study for folks who
7 detransitioned by those aspects that you noted.

8 BY ATTORNEY BARHAM:

9 Q. Okay.

10 But she notes in the last paragraph on that
11 page the objective of the current study was to describe
12 the population of individuals, skipping, who then
13 detransitioned by discontinuing medications, having
14 surgery to reverse the effects of transition or both?

15 A. That's correct.

16 Q. So she is indicating what she understands
17 detransitioning to mean in this article.

18 Correct?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: Again I'm not sure how she
21 specifically defines detransition. It is not
22 necessarily made clear in that statement.

23 BY ATTORNEY BARHAM:

24 Q. Is it true that people may mistake feelings

1 resulting from trauma, mental illness or homophobia for
2 a genuine sense of transgender identity?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: I think there are a lot of
5 complicated experiences that people may have that make
6 them question their gender identity.

7 BY ATTORNEY BARHAM:

8 Q. So it's at least possible that people could
9 mistake feelings resulting from trauma, mental illness
10 or homophobia for genuine sense of transgender identity.

11 Correct?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: I don't disagree with that,
14 no.

15 BY ATTORNEY BARHAM:

16 Q. You said it's complicated, so it sounds like it
17 would be hard sometimes for a clinician to tell with
18 certainty what's going on?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: What I would describe is
21 that in anything related to mental health that there are
22 complications and nuances. This is no different.

23 BY ATTORNEY BARHAM:

24 Q. Now, I believe you alluded to this a moment ago.

1 You mentioned that this is a self-reporting study and it
2 obviously concerns an emotionally fraught area of gender
3 identity. So is it your position that this does not
4 produce scientifically meaningful results?

5 A. I don't know what you mean by scientifically
6 meaningful.

7 Q. Do you believe that this --- the results of this
8 article are scientifically reliable?

9 A. It depends upon what question is being asked.
10 As a blanket, any kind of selection bias, particularly
11 for this study based upon where the participants were
12 drawn from makes us not want to draw conclusions about
13 their generalized applicability of this study to other
14 transgender folks, including other folks who may have
15 detransitioned, but the goal of science is not
16 necessarily to draw widely applicable conclusions, but
17 to put us in a position where we can ask more questions
18 and improve our care for our patients.

19 Q. Now, why do you say --- why do you highlight
20 concerns about where the participants were drawn from?

21 A. I highlight that because it creates a sense of
22 selection bias, which potentially, as I said, can reduce
23 the why applicability of the conclusions drawn.

24 Q. And why do you say that there is a potential for

1 selection bias in this article?

2 A. Based upon the websites that Dr. Littman has
3 drawn her participants.

4 Q. And why do you have concerns about those
5 websites?

6 A. I have concerns about the websites because of
7 the contents of those websites.

8 Q. And what is contents of those websites that
9 causes you concern?

10 A. The content of the websites is unscientific.
11 And I guess I'm not sure how to articulate it in a most
12 defined way very specific to answering a set of
13 questions that reenforces the prestudy hypotheses.

14 Q. So which websites that she drew participants
15 from cause you concern?

16 A. As an example, Fourth Wave Now is a website that
17 Dr. Littman had used for some of her study recruitment.

18 Q. And why are you concerned about the use of
19 Fourth Wave now in the recruitment process?

20 A. What I would say is that when you're designing a
21 study that presupposes the conclusion and the website is
22 designed to attract people who presuppose that
23 conclusion, that limits the applicability of the
24 results. It just have to be taken into account. It

1 doesn't mean that there isn't data from this kind of
2 snowball recruitment that isn't valuable and I wouldn't
3 say that there isn't value to some of Dr. Littman's
4 work, specifically this study as compared to the last,
5 though you have to take it in the context with which it
6 was developed.

7 Q. So are you suggesting that Dr. Littman
8 presupposed the conclusion that she wanted to reach in
9 designing this survey?

10 A. I'm less familiar with the design of this study
11 than previous studies that she has designed, which I
12 would say that was correct.

13 Q. What other websites did she use in the process
14 to cause you concern?

15 A. I'm not as familiar with this study, so I don't
16 know if she specifically identified which websites. And
17 I can't recall right now on the others which they were.

18 Q. If you look at page three she discusses the
19 method and the participants and procedures. Would
20 reviewing that refresh your recollection as to any
21 concerns about participants?

22 A. It would not because she does not describe the
23 specific fora. She describes a closed Facebook group,
24 Tumbler, Twitter and Reddit, but those are large

1 websites that have a lot of different kind of content.

2 Q. So is it your position that it's not possible to
3 know whether anonymous or any results have any relation
4 to true fact in actual case histories?

5 A. That is not my position.

6 Q. Do you have any --- you mentioned earlier
7 something about how these were anonymous results. So is
8 it possible to know whether they actually corresponded
9 with true cases?

10 A. I think anonymous surveys, you have to really
11 dig into the specifics of the survey design in order to
12 draw conclusions. And again, with any study in any
13 survey in particular you just want to make sure you have
14 an understanding of that context how broadly to draw
15 conclusions.

16 Q. Would you agree that online recruitment does not
17 provide a statistically meaningful sample?

18 A. I would not agree with that.

19 Q. Is it your position --- how can an online
20 recruitment produce a statistically meaningful sample?

21 A. I think I would need to understand the context
22 of what you mean by statistically meaningful. There is
23 a difference between a survey that could be potentially
24 poorly designed and yet reach statistical significance.

1 You would need to understand the broader context in
2 order to draw conclusions about what that statistical
3 significance means and that means really digging into
4 the specific methodology of this study. There is a vast
5 literature about efficacy of survey data and it really
6 depends on the specifics.

7 Q. We've previously referenced paragraph eight of
8 your report where you mention you've seen approximately
9 500 transgender patients.

10 ATTORNEY BLOCK: Travis, sorry, not to
11 avoid a pending question, but we're almost at one hour,
12 so if this is a good time, if you're moving to a
13 different subject maybe this would be a good time to
14 break.

15 ATTORNEY BARHAM: Let me wrap up a few
16 more and then we will do that.

17 ATTORNEY BLOCK: Thanks.

18 BY ATTORNEY BARHAM:

19 Q. Your clinical practice for children and
20 adolescents started in 2013, about eight years ago.

21 Is that correct?

22 A. No, I finished medical school in 2011 and have
23 been working with adults, children and adolescents since
24 then.

1 Q. Okay.

2 A. Actually that's when I finished --- to go back,
3 that's when I finished my residency and fellowship. I
4 finished medical school in 2006. I can't believe it's
5 been long.

6 Q. And when did you begin your work in child and
7 adolescent psychiatry?

8 A. I had child and adolescent psychiatry
9 experiences when I was in medical school.

10 Q. When did you begin practicing child and
11 adolescent psychiatry?

12 A. That's not a very specific term. I practiced
13 child psychiatry as a medical student in my training.

14 Q. When were you licensed, when were you first
15 licensed to practice child and adolescent psychiatry?

16 A. There's no specific license to practice child
17 psychiatry. Anybody who is --- has a medical license
18 can practice any medical specialty. I was Board
19 Certified in Child and Adolescent Psychiatry, which is a
20 different process and I would have to look through to
21 recall the date. I'm assuming that it's 2012 or 2013.
22 2013 is when I was Board Certified.

23 Q. So when did you begin --- and you finished your
24 fellowship in child and adolescent psychiatry when?

1 A. 2011.

2 Q. 2011. When did you begin treating as a child
3 and adolescent psychiatrist children with gender
4 dysphoria?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: I saw children with gender
7 dysphoria during my residency and in my fellowship.

8 BY ATTORNEY BARHAM:

9 Q. And your fellowship?

10 A. Between 2006 and 2009.

11 Q. And what proportion of those patients socially
12 transitioned?

13 A. Of all of the patients that I saw in my training
14 or in all of the patients that I've seen over my time as
15 a physician?

16 Q. Let's go first with the training.

17 A. It was a much smaller number, so probably if I
18 were to guess, and I'm going back, probably close to
19 95 percent.

20 Q. Ninety-five (95) percent socially transitioned
21 when you were in training?

22 A. Yes.

23 Q. And how many of your patients overall have
24 socially transitioned?

1 A. I'm not sure how to answer that question. Over
2 the course of our time working together, before I
3 started seeing them or --- I'm not sure how to
4 accurately answer that question.

5 Q. Over the --- just in general how many of your
6 patients socially transitioned, not just while they were
7 being treated under your care?

8 A. And these are patients who are seeing me
9 specifically through the context of gender or of those
10 500 transgender patients?

11 Q. Of the 500 transgender patients.

12 A. Probably --- I mean, it's a guess but probably
13 in the order of 85 percent.

14 Q. And what proportion of the 500 patients used
15 puberty blockers?

16 A. Probably a minority of those patients. If I had
17 to guess, probably 20 percent or less.

18 Q. And what percent of those 500 transgender
19 patients used cross sex hormones?

20 A. I don't have my records in front of me, so it
21 would really just be a guess, but probably close to the
22 same percentage that socially transitioned, probably a
23 little bit less than that.

24 Q. If I recall correctly that's about 85 percent?

1 A. Probably somewhere on the order of that.

2 ATTORNEY BLOCK: Would now be a good time
3 for that break?

4 ATTORNEY BARHAM: One last question.

5 BY ATTORNEY BARHAM:

6 Q. What systems do you have in place to track these
7 patients five years after they have been in your care?

8 A. I have the same systems as most psychiatrists.
9 We see the patients within our care. Folks will reach
10 out to us after time has passed and it's one of the
11 great pleasures of being a child psychiatrist, we get to
12 see folks longitudinally. So there is not a specific
13 system apart from mutual care.

14 Q. So you rely on them to reach out to you.
15 Is that correct?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: It depends on context.

18 BY ATTORNEY BARHAM:

19 Q. But do you have any systematic way of tracking
20 all patients five years after they leave your care?

21 A. There is no systematic way of tracking all
22 patients.

23 ATTORNEY BARHAM: All right. Let's take
24 a break. How long would you all like?

1 | ATTORNEY BLOCK: Five minutes.

2 | ATTORNEY BLOCK: Should we go off the
3 | record?

4 | VIDEOGRAPHER: Going off, 10:14 a.m.

5 | OFF VIDEOTAPE

6 | ---
7 | (WHEREUPON, A SHORT BREAK WAS TAKEN.)

8 ---
9 ON VIDEOTAPE
10 VIDEOGRAPHER: Back on the record. The
11 time is 10:27 am.

12 BY ATTORNEY BARHAM:

13 Q. Moments ago we were discussing Dr. Littman's
14 2021 study, that was Tab 15, Exhibit 6. Are you aware
15 of any studies that contradict Dr. Littman's data?

16 | A. Can you be more specific?

17 Q. Are you aware of any studies that contradict Dr.
18 Littman's work survey in this article in Exhibit-6 that
19 find fault with her data?

20 ATTORNEY BLOCK: Objection to the form.

21 THE WITNESS: Yeah. I'm sorry. I don't
22 think I understand the question. There are other
23 articles that have been written about detransition and
24 clinical experiences of patients that have

1 detransitioned who have described those experiences.

2 There has not been a specific survey designed of
3 detransitioners outside of this one that I'm aware of.

4 BY ATTORNEY BARHAM:

5 Q. Has anyone written an article finding fault with
6 the way Dr. Littman interpreted the data that ---?

7 ATTORNEY BLOCK: Objection to form.

8 THE WITNESS: For this specific data set
9 or for previous?

10 BY ATTORNEY BARHAM:

11 Q. For this specific data set?

12 A. For this specific data set, from my
13 recollection, this was studied --- or published just
14 recently so I'm not aware of any. It doesn't mean that
15 there aren't.

16 Q. Are you aware of any studies that contradict Dr.
17 Littman's conclusions in this 2021 article?

18 A. If you give me a moment I will read the
19 conclusion.

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: Insomuch as Dr. Littman's
22 conclusion is that there's no single narrative to
23 explain the experiences of all individuals who
24 detransitioned and we should take care to avoid painting

1 the population with a broad brush, I agree with that
2 conclusion.

3 BY ATTORNEY BARHAM:

4 Q. Are you aware of any studies that contradict her
5 conclusions not just in the conclusion section but her
6 description of the detransitioners?

7 ATTORNEY BLOCK: Objection to the form.

8 THE WITNESS: I think it's hard to
9 provide a specific answer to that question. We have to
10 look at each study and judge each individual study based
11 upon the merits. The conclusions she draws are from a
12 subset of patients with a very specific viewpoint, and I
13 agree with her and her conclusion that there needs to be
14 more research to better understand the broader
15 implications of this care.

16 BY ATTORNEY BARHAM:

17 Q. You're not aware of any article that has been
18 published specifically critiquing this 2021 study by Dr.
19 Littman.

20 Is that correct?

21 A. Not that I'm aware of.

22 ATTORNEY BLOCK: Objection to form.

23 BY ATTORNEY BARHAM:

24 Q. A few moments ago we were also talking about the

1 patients that you have treated, the 500 transgender
2 patients you referenced in your report, and you
3 mentioned that about 20 percent or less of those had
4 used puberty blockers. I'm wondering why that
5 percentage is so low.

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: I don't know. Low compared
8 to what? I think it's important to understand the
9 context that in 2011, when I first started my gender
10 program, that puberty blocking medications were not
11 widely available, cost upwards of \$3,000 a month and
12 were not covered by most insurance. So puberty blockers
13 were not something that were available in the same way
14 they are now. And I also saw a fair number of adults
15 and older adolescents for whom puberty blockers are not
16 indicated.

17 BY ATTORNEY BARHAM:

18 Q. So of the 500 patients that you reference in
19 paragraph eight of your report, what percentage of those
20 are adults?

21 A. I would really have to go back and look. I
22 mean, in my current practice, I see adolescents and
23 young adults, so kind of parsing out artificially who is
24 18 and up, it would take some time to do that. Probably

1 in the order of 75 percent are children in adolescence,
2 25 percent adults. But of course, over 2011 to now, a
3 lot of those folks are now adults.

4 Q. And when I'm asking about these percentages I
5 mean when you were treating them. What percentage of
6 the patients you were treating were children?

7 A. That's my best guess.

8 Q. Seventy-five (75) percent?

9 A. Yes.

10 Q. And are you distinguishing between prepubertal
11 children and adolescents in that 75 percent or both?

12 A. That's both.

13 Q. Of that 75 --- of all the patients you've seen,
14 at the time you saw them, how many were prepubertal
15 children?

16 A. Probably --- and again, I have to give this a
17 major caveat. I would have to go back and look through
18 everything, but I would say probably 25 percent of that
19 75 percent were prepubertal at the time of initial
20 assessment.

21 Q. And so then the remaining 75 percent of 75 would
22 be adolescents.

23 Is that correct?

24 A. Correct.

1 ATTORNEY BLOCK: Objection to form.

2 BY ATTORNEY BARHAM:

3 Q. How many of your patients of those 500 patients
4 have detransitioned in a year?

5 A. It's kind of a hard question to answer. The one
6 patient who self identifies as having detransitioned
7 started seeing me after she had detransitioned.

8 Q. Have any of your patients detransitioned while
9 under your care?

10 A. Not that I'm aware of.

11 Q. And is the one patient who detransitioned before
12 starting to see you, is that the only patient you're
13 aware of of the 500 that has detransitioned?

14 A. That is the only one that I'm aware of, yes.
15 But can I clarify that of those 500 patients there are
16 certainly those who did not choose to transition.

17 Q. And how many of the 500 chose not to transition?

18 A. If I had to guess, probably about 10 to 20,
19 probably ten percent.

20 Q. And did they make that decision before puberty
21 began?

22 A. It was a mix.

23 Q. Of those who chose not to transition, how many
24 were children when they made that decision?

1 A. I couldn't tell you at that point, but
2 significantly more were the prepubertal youth than
3 adolescents.

4 Q. This is a sensitive question. I mean no offense
5 by it, but how many of the 500 patients have made the
6 sad decision to commit suicide?

7 ATTORNEY BLOCK: I'm sorry. I couldn't
8 heat that. Can you speak up?

9 BY ATTORNEY BARHAM:

10 Q. How many of the 500 patients have made the sad
11 decision to commit suicide?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: Is your question how many
14 have completed suicide?

15 BY ATTORNEY BARHAM:

16 Q. Correct.

17 A. Of those 500 patients, zero.

18 Q. How many of those 500 patients have been
19 hospitalized for a psychiatric illness?

20 A. I do not have that information in front of me.

21 Q. Do you have any general idea?

22 A. I don't.

23 Q. After five or more years what percentage of your
24 patients would be characterized as lost to follow-up?

1 A. Lost to follow-up is a specific term used in
2 studies, so it's not something that I would use to
3 describe my patients.

4 Q. How many patients do you lose contact with after
5 five years?

6 A. Again, I don't know how to answer that question.
7 I've been at my current role for three, so I haven't
8 lost touch with any significant number of patients.

9 Q. What about patients that you saw before you were
10 in your current position?

11 A. I'm not in contact with patients from my
12 previous role.

13 ATTORNEY BARHAM: All right. Let's go to

14 Tab 110. This is Exhibit-7 I believe.

15 | -----

16 (Whereupon, Exhibit-7, Study, was marked
17 for identification.)

18 | -----

19 BY ATTORNEY BARHAM:

20 Q. Are you familiar with this study?

21 | A. I am not.

22 Q. Have you seen it before today?

23 | A. I have not.

24 Q. On page one this again has been --- it's

1 paginated in the top right corner or top inside corner.
2 On page one the first sentence of the last paragraph
3 says gender transition is as scientifically fascinating
4 as it is socially controversial for it poses significant
5 professional and bioethical challenges for those
6 clinicians working in the field of gender dysphoria.

7 Do you agree that gender detransition poses
8 significant professional and bioethical challenges for
9 professionals treating gender dysphoria?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: I don't necessarily agree
12 with the language. And certainly don't agree with the
13 author to use something that's scientifically
14 fascinating. What I think is that every decision that
15 we make in child psychiatry in particular is fraught
16 with ethical challenges. This is not any different from
17 the ethical challenges that we face with a lot of other
18 interventions.

19 BY ATTORNEY BARHAM:

20 Q. What challenges does detransition pose to your
21 profession in your view?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: I don't see how it poses
24 any challenges to my work.

1 BY ATTORNEY BARHAM:

2 Q. Page three of this article, the authors identify
3 several things that may prompt a person's decision to
4 detransition including understanding how past trauma,
5 internalized sexism and other psychological difficulties
6 influence the experience of gender dysphoria.

7 Correct?

8 ATTORNEY BLOCK: Objection. Can you give
9 him a chance to read?

10 ATTORNEY BARHAM: Of course.

11 THE WITNESS: And can you repeat what you
12 said?

13 BY ATTORNEY BARHAM:

14 Q. On page three the authors identify several
15 things that may prompt a person's decision to
16 detransition including, quote, understanding how past
17 trauma, internalized sexism and other psychological
18 difficulties influence the experience of gender
19 dysphoria.

20 Correct?

21 A. Sorry. Just give me a second to look at the
22 context here.

23 Q. Sure.

24 A. I agree that's how it is written and there

1 appears to be no basis from which the author has built
2 that assertion. There is no methods described in this
3 whatsoever.

4 Q. I believe the author in that instance is citing
5 Dodsworth 2020, Gonzalez 2019, Herzog 2017, and one,
6 two, three, four other studies.

7 Do you see that?

8 A. I see those studies. I'd have to look at the
9 specific studies in order to understand the implications
10 and the context.

11 Q. But the authors obviously seem to have a basis
12 or at least a citation basis for what they're saying.

13 Is that correct?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: Again, without knowing the
16 specifics of those studies it's hard for me to say.

17 BY ATTORNEY BARHAM:

18 Q. The authors also indicate that solving previous
19 psychological or slash emotional problems that
20 contributed to gender dysphoria may prompt the decision
21 to detransition.

22 Is that correct?

23 A. Where is that?

24 Q. They are citing Butler and Hutchinson, 2020,

1 Stella 2016. It is the same paragraph.

2 A. Got it. Yeah I don't know what solving a
3 psychological or emotional problem means in this
4 context.

5 Q. But these authors are at least indicating that
6 solving these problems, however they mean the term, may
7 prompt a decision to detransition.

8 Is that correct?

9 ATTORNEY BLOCK: Objection to form.

10 THE WITNESS: I think I've answered how I
11 can answer that.

12 BY ATTORNEY BARHAM:

13 Q. Okay.

14 Let's go back to Tab 15, which is Exhibit-6.
15 This was the Littman study that we were discussing a
16 moment ago. On page three --- excuse me, according to
17 Table 5, on page nine, 60 percent of the participants in
18 this survey reported that they became more comfortable
19 identifying as their natal sex.

20 Is that correct?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: I see 65 percent of those
23 assigned female at birth and 48 of those assigned male
24 at birth reported that.

1 BY ATTORNEY BARHAM:

2 Q. So 45 and 15 is 60, so that would be 60 percent
3 of the 100 participants in the study.

4 Correct?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: I believe.

7 BY ATTORNEY BARHAM:

8 Q. I'm sorry. I didn't hear your answer.

9 A. I trust your math, yes.

10 Q. Okay.

11 And on page 12, under the heading discussion,
12 this survey indicates that only a small percentage of
13 detransitioners, 24 percent, informed the clinicians and
14 clinics that facilitated their transfer that they ---
15 their transition that they had detransitioned.

16 Is that correct?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: Yes, the participants in
19 the study, that is correct.

20 BY ATTORNEY BARHAM:

21 Q. And you testified a moment ago, if I recall
22 correctly, please correct me if I'm wrong, that you are
23 aware of only one patient in your career that has
24 detransitioned.

1 Is that correct?

2 A. That I'm aware of, yes.

3 Q. Let's go to Tab 116, which is Exhibit-8.

4 ---

5 (Whereupon, Exhibit-8, Article by
6 Vandebussche, was marked for
7 identification.)

8 ---

9 BY ATTORNEY BARHAM:

10 Q. Are you familiar with this article?

11 A. I have not read this article.

12 Q. And this is a 2021 article by I believe a
13 gentleman named --- or an individual named
14 Vandebussche, Detransitioned Related Needs in Sports.

15 Is that correct?

16 A. That is correct.

17 Q. Did you review this article when preparing your
18 report?

19 A. I did not.

20 Q. If you look at page four this article examined a
21 sample survey of 237 detransitioners.

22 Is that correct?

23 ATTORNEY BLOCK: Objection. Can you give
24 him time to read the document he has never seen before.

1 ATTORNEY BARHAM: Certainly.

2 THE WITNESS: Can you repeat the
3 question?

4 BY ATTORNEY BARHAM:

5 Q. This article highlights the results of a survey
6 of 237 detransitioners.

7 Correct?

8 A. Yes, as they are defining detransitioning, yes.

9 Q. And on page five these authors --- these
10 researchers report that 70 percent of participants
11 detransitioned because they realized that their gender
12 dysphoria was related to other issues.

13 Correct?

14 A. Correct.

15 Q. And that was the most common reported reason for
16 detransitioning.

17 Correct?

18 A. As they stated, yes.

19 Q. In paragraph 43 of your report you cite Lisa
20 Littman's 2018 study. Paragraph 43. And you highlight
21 what you describe as serious methodological flaws that
22 render the study meaningless.

23 Is that correct?

24 A. Correct.

1 ATTORNEY BARHAM: I want to show you
2 Tab 117, and this will be Exhibit 9. It will be an
3 article by Lily Durwood entitled Mental Health and Self
4 Worth in Socially Transitioned Transgender People.

5 ---

6 (Whereupon, Exhibit-9, Article by Lily
7 Durwood, was marked for identification.)

8 ---

9 BY ATTORNEY BARHAM:

10 Q. Are you familiar with this article?

11 A. I am.

12 Q. You cited this in footnote nine of your report
13 as demonstrating the treatment associated with social
14 transitions.

15 Correct?

16 A. I have to look at the specific footnote. I know
17 I cited it, but I don't know if it was citing to that
18 specific conclusion.

19 Q. By all means take a look.

20 A. Can you point me to where my footnote is?

21 Q. Footnote nine is --- let me find it myself.

22 ATTORNEY SWAMINATHAN: It's page 11.

23 THE WITNESS: Yes.

24 BY ATTORNEY BARHAM:

1 Q. The Durwood article in 2017 is a survey of
2 children and their parents about the children's mental
3 health.

4 Is that correct?

5 A. Correct.

6 Q. The children in the Durwood article were not
7 surveyed or assessed by clinicians.

8 Is that correct?

9 A. I don't know the answer to that. I'd have to
10 look at the specific ---.

11 Q. Well, if this is a self report it would be
12 reporting what the children themselves said.

13 Correct?

14 ATTORNEY BLOCK: Objection. Let him have
15 time to read the article.

16 THE WITNESS: The trans youth project was
17 directed by Dr. Ulson involved clinicians in the
18 assessment of the children and their families. So I'm
19 not sure specifically. I would have to go through the
20 methods of this one particularly for me to recall.

21 As you will see from the procedure on
22 page 117 whenever possible parents and children
23 completed the measurements in separate rooms or far
24 enough in the same room to be out of ear shot. And so

1 they were researchers who were boarded who were
2 participating in these interviews with the kids and
3 their families.

4 BY ATTORNEY BARHAM:

5 Q. But those researchers were just recording what
6 the students said out loud?

7 A. Correct.

8 Q. So there's no clinical assessment of the
9 children as part of this survey.

10 Is that correct?

11 ATTORNEY BLOCK: Object to form.

12 THE WITNESS: I wouldn't be able to
13 answer that question. It depends upon how it's used.
14 In a research context you might be using the same
15 instruments that we would use for clinical assessments,
16 but for the sake of research purposes it's not used in
17 that way.

18 BY ATTORNEY BARHAM:

19 Q. But the purpose of this article was just to
20 record what the children said as a self report.

21 Is that correct?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: As far as I understand the
24 point of this article, they utilized child self report

1 which is what is typically used in children mental
2 health studies.

3 BY ATTORNEY BARHAM:

4 Q. According to page --- the second page of this
5 article, which is page 117, the participants were
6 recruited through word of mouth, national and local
7 support groups, summer camps and online forums for
8 families of transgender and gender nonconforming youth.

9 Correct?

10 A. That is correct.

11 Q. Frequently in your report you refer to
12 gender-affirming care. What in your view are the
13 components of gender-affirming care?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: I think that there is no
16 one agreed upon use of that term and it is used by
17 different people in different context to mean whatever
18 they want it to mean, depending upon who is asking the
19 questions. The way that I define it, for my own
20 practice, is that it's important for children to be
21 heard and listened to, that any particular gender
22 identity outcome is not better than any other and that
23 the child and families should be directing the process
24 with appropriate assessments and interventions.

1 BY ATTORNEY BARHAM:

2 Q. How do you handle a situation where parental
3 desires may be differ than the child's desires?

4 A. That is almost a universal phenomenon of
5 parenthood, so there's not an atypical process. When
6 there is disagreement about specific issues in the
7 treatment plan those interventions are going to be
8 tailored to the individual families based upon their
9 need.

10 Q. So when you use gender-affirming care what do
11 you view as the different components or different
12 aspects of gender-affirming care in your practice?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: I think that is also going
15 to be highly context dependent. I'm a psychiatrist and
16 I see a lot of children with complex psychiatric needs,
17 so my process for gender-affirming care is going to be
18 different than what somebody else might describe as
19 gender-affirming care, but I think I highlighted what I
20 see as the components of it for myself.

21 BY ATTORNEY BARHAM:

22 Q. I've missed in your list of the different
23 components, so could you explain again what do you see
24 as the components of gender-affirming care?

1 A. That it should be child and family led, that
2 listening to and understanding the child is an important
3 aspect of the process and that there is no gender
4 identity outcome that is privileged over another. I'm
5 sure I said it slightly differently than the last time
6 around but the concepts are the same.

7 Q. Do you consider social transition to be a
8 component of gender-affirming care?

9 A. I think that understanding the risks, benefits
10 and alternatives of social transition is a part of
11 gender-affirming care. In that way, sometimes
12 recommending not socially transitioning is a part of
13 gender-affirming care.

14 Q. But gender-affirming care can be an approach
15 used as part of gender-affirming care.

16 Is that correct?

17 ATTORNEY BLOCK: Objection to the form.

18 THE WITNESS: Can you repeat the
19 question?

20 BY ATTORNEY BARHAM:

21 Q. Social transitioning can be a method used as
22 part of gender-affirming care.

23 Correct?

24 A. It is an option.

1 Q. An available tool.

2 Correct?

3 A. Yes.

4 Q. Is it your belief that social transition is a
5 type of medical or mental health treatment for gender
6 dysphoria?

7 A. It's a hard question to answer. Social
8 transition is a pretty diverse concept that's hard to
9 get as a categorical variable to study, but the
10 implication is that there's a lot of things that are
11 often helpful for mental health that aren't specifically
12 mental health treatments, right, like exercise, regular
13 sleep. These aren't specific mental health
14 interventions but nevertheless have impacts on mental
15 health outcomes.

16 Q. Well, in paragraph 90 --- I mean paragraph 36 of
17 your report you say that social transition is a
18 treatment for gender dysphoria?

19 A. Yeah I would agree with that.

20 Q. So what kind of treatment is it?

21 A. It's a psychosocial intervention.

22 Q. Psychosocial. What does social transitioning
23 include in your view?

24 A. I have to recall if I provided an operational

1 definition for it in my report. Essentially what we're
2 talking about is an alignment of gender role and gender
3 identity. So that's transition of name, pronouns, hair,
4 participation in sex-segregated activities, et cetera.

5 Q. And so social transition in your view means the
6 participation in girls or boys athletic teams in
7 competitions consistent with ones gender identity.

8 Is that correct?

9 A. Again, it's going to be context dependent. It
10 is not a yes or no question around social transition.
11 What we're going to be doing in the context of an
12 assessment is understanding the risks and benefits of
13 all the various options that we have.

14 Q. I understand that it can differ from person to
15 person, but participation in girls or boys athletic
16 teams in competition consistent with one's gender
17 identity is an aspect, a possible aspect, of social
18 transitioning.

19 Correct?

20 A. It may be an option for some students, yes.

21 Q. Do you consider the use of puberty blockers to
22 be an available tool as part of gender-affirming care?

23 A. I do.

24 ATTORNEY BLOCK: Objection to form.

1 BY ATTORNEY BARHAM:

2 Q. Do you consider the use of cross sex hormones to
3 be an available tool as part of gender-affirming care?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: Gender-affirming care can
6 include hormones.

7 BY ATTORNEY BARHAM:

8 Q. Are there any other available tools that you use
9 as part of gender-affirming care?

10 A. Yes, there is a lot of tools that I use that are
11 involved in gender-affirming care. Work with the family
12 is one big piece of it. Work with the school is
13 another. Referrals for surgery when indicated,
14 recommendations for assessment and treatment of any
15 co-occurring mental health disorder is a part of it.

16 Q. What is your role in the prescribing of puberty
17 blockers?

18 A. I'm occasionally in the role of doing a mental
19 health assessment prior to initiation of those
20 medications.

21 Q. And are you the individual who would prescribe
22 the puberty blockers?

23 A. I am not.

24 Q. What type of professional would be responsible

1 for the prescribing?

2 A. In the clinics that I have worked these are
3 either adolescent medicine specialists or pediatric
4 endocrinologists.

5 Q. And is the same true with cross sex hormones?

6 A. Yes.

7 Q. In your report you describe gender-affirming
8 care as the prevailing model of care for transgender
9 youth.

10 Is that correct? And I'm referencing
11 paragraph 15 of your report.

12 A. Yes.

13 Q. Later on in your report you refer to prevailing
14 standards of care, paragraph 18, paragraph 26, for
15 example. By that are you referring to gender-affirming
16 care?

17 A. Which paragraph?

18 Q. Eighteen (18) and 26.

19 A. I would say that it is a part of what I'm
20 referring to but not the entirety of what I'm referring
21 to.

22 Q. What else are you referring to in paragraph 18
23 and 26 when you say prevailing standards of car?

24 A. This would include a lot of components,

1 including both the Endocrine Society Guidelines, the
2 World Professional Association for Transgender Health
3 Guidelines as well as recommendations and ethical
4 guiding principles of the various governing bodies that
5 we all work with.

6 Q. And you would describe those various documents
7 that you just referenced as reflecting gender-affirming
8 care.

9 Correct?

10 A. I would have to go through, for example, the
11 Endocrine Society Guidelines to know whether or not they
12 use that specific term. Again, I think I just want to
13 make sure that I'm emphasizing that gender-affirming
14 care does not have an agreed upon definition so it's
15 controversial and I wouldn't know how to answer that
16 question.

17 Q. As you use the term and as you define the term
18 in your practice, would you consider the WPATH standards
19 to fall under the umbrella of gender-affirming care?

20 A. I would yes.

21 Q. And would you consider the Endocrine Society
22 Guidelines to fall under the umbrella of
23 gender-affirming care?

24 A. I would, yes.

1 Q. In paragraph 15 of your report you claim that
2 gender-affirming care is endorsed by at least five
3 professional associations.

4 ATTORNEY BLOCK: Objection to form.
5 BY ATTORNEY BARHAM:

6 Q. And you reference others. What other
7 organizations are you alluding to in paragraph 15 of
8 your report?

9 A. I don't want to get the name of the organization
10 incorrect, but National Association of Social Workers
11 and the National Association of Marital and Family
12 Therapists have released statements about it, but I
13 don't have specific recollection of those sitting here
14 today.

15 Q. Okay.

16 Are there any other organizations besides those
17 and those listed in paragraph 15?

18 A. There likely are but none that are coming to
19 mind today.

20 Q. When you were preparing your report did you
21 consult the standards of care articulated by any
22 international professional organizations?

23 A. Yes.

24 Q. Which ones?

1 A. Both the Endocrine Society Guidelines as well as
2 the WPATH standards of care.

3 Q. Any other international or professional
4 organizations?

5 | A. Not that I can recall, no.

6 Q. Are you aware that international and
7 professional organizations have been moving away from
8 using puberty blockers and cross sex hormones on
9 children and adolescents under the age of 16?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: I don't see that that is
12 necessarily accurate. I'm going to have to take a break
13 in five minutes if that is okay.

14 ATTORNEY BARHAM: This would be the
15 perfect time.

16 THE WITNESS: I will be quick.

17 VIDEOGRAPHER: Going off the record. The
18 current reads 11:01.

19 | OFF VIDEOTAPE

20 | ---

21 (WHEREUPON, A SHORT BREAK WAS TAKEN.)

22 | ---

23 | ON VIDEOTAPE

24 VIDEOGRAPHER: Back on the record. The

1 current time is 11:06 a.m.

2 ATTORNEY BARHAM: I'm going to show you
3 what we will mark as Exhibit 10, this will be Tab 91.

4 ---

5 (Whereupon, Exhibit-10, Statement by
6 Royal Australian and New Zealand College
7 of Psychiatrists, was marked for
8 identification.)

9 ---

10 BY ATTORNEY BARHAM:

11 Q. This is a statement from the Royal Australian
12 and New Zealand College of Psychiatrists.

13 Correct?

14 ATTORNEY BLOCK: Objection. Can you give
15 him a chance to look at the document?

16 THE WITNESS: It's what it says. I don't
17 know what the government structure of this organization
18 is or how they release their statements or how they are
19 developed.

20 BY ATTORNEY BARHAM:

21 Q. This is Position Statement 103, according to the
22 document.

23 Correct?

24 A. I will take your word for it if that's what it

1 says.

2 Q. Right below the title. And it was published in
3 August of 2021.

4 Is that correct?

5 A. I don't know where it says that.

6 Q. Right below the tab.

7 A. Got it.

8 Q. The Royal Australian and New Zealand College of
9 Psychiatrists is the professional body of psychiatrists
10 for those two countries.

11 Is that correct?

12 ATTORNEY BLOCK: Objection.

13 THE WITNESS: I do not know that.

14 BY ATTORNEY BARHAM:

15 Q. I'm sorry. I didn't catch your answer.

16 A. I do not know.

17 Q. According to page three of this document, the
18 Royal College has concluded that there are, quote,
19 polarized views and mixed evidence regarding treatment
20 options for people presenting with gender identity
21 concerns, especially children and young people.

22 Do you see that?

23 A. I see that.

24 Q. Do you agree with their assessment?

1 A. Yes.

2 Q. So this means that professionals can disagree
3 with each other as to how to treat children and young
4 people with gender dysphoria.

5 Is that correct?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: Yeah. I think any
8 treatment decision, you're going to have professionals
9 disagreeing with you about the best course of action.
10 This isn't any different than that.

11 BY ATTORNEY BARHAM:

12 Q. And on page four of the document the Royal
13 College says that psychiatric assessment and treatment
14 should be both --- should be both based on available
15 evidence and allow for full exploration of a person's
16 gender identity. And it emphasizes the importance of
17 the psychiatrist's role to undertake for assessment in
18 evidence-based treatment ideally as part of a
19 multidisciplinary team, especially highlighting
20 distinguishing issues which may need addressing and
21 treating. Do you agree with the Royal College's
22 emphasis on psychiatrists' role and how it's important
23 to ensure appropriate care for gender dysphoria?

24 ATTORNEY BLOCK: Objection to form.

1 THE WITNESS: Psychiatrists are often a
2 useful adjunct to the team, but isn't a necessary
3 requirement. There are many other mental health
4 professionals who have expertise and can fill this role.

5 BY ATTORNEY BARHAM:

6 Q. And what other professionals do you think could
7 fill this role?

8 A. This would be licensed clinical mental health
9 professionals.

10 Q. And those would include?

11 A. Psychologists, social workers, marital and
12 family therapists and there are probably other titles
13 that are governed by their regulatory boards that I
14 don't recall right now.

15 BY ATTORNEY BARHAM:

16 Q. And on what are you basing your disagreement
17 with the Royal College's emphasis on the importance of
18 the psychiatrist's role

19 ATTORNEY BLOCK: Objection to form and
20 characterization of the document.

21 THE WITNESS: The WPATH standards of care
22 as an example does not dictate necessary involvement of
23 a psychiatrist. And I would have to review the
24 Endocrine Society, but I don't believe that they

1 specifically --- from my guild either.

2 BY ATTORNEY BARHAM:

3 Q. Is it true that psychiatrists have training and
4 skills that psychologists and marital therapists and
5 social workers do not have?

6 A. That is correct.

7 ATTORNEY BARHAM: I'm going to hand you
8 what we will mark as Exhibit-11. And this will be
9 Tab 92 for those watching online.

10 ---

11 (Whereupon, Exhibit-11, Policy Change
12 Regarding Hormonal Treatment of Minors,
13 was marked for identification.)

14 ---

15 BY ATTORNEY BARHAM:

16 Q. This document is an announcement of a policy
17 change regarding hormonal treatment of minors with
18 gender dysphoria at Astrid Lidgren Children's Hospital.
19 Are you aware that this is the main gender clinic in
20 Sweden?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: I don't see any specific
23 information about this document that reports where it's
24 from.

1 BY ATTORNEY BARHAM:

2 Q. Are you aware of Astrid Lindgren Hospital by
3 reputation?

4 A. I don't know if that's the name of it. No, I
5 don't recall the specific name of the Swedish Children's
6 Hospital.

7 Q. Are you aware that the Swedish Agency for Health
8 Technology Assessment and Assessment of Social Services
9 published an overview of the knowledge base which showed
10 a lack of evidence of both long-term consequences of the
11 treatments of gender dysphoria?

12 A. I have heard ---.

13 ATTORNEY BLOCK: Objection to form and
14 where are you quoting from?

15 ATTORNEY BARHAM: Halfway through the
16 first paragraph of the background section on page one.

17 ATTORNEY BLOCK: I'm sorry. Where was
18 this document obtained from?

19 ATTORNEY BARHAM: I can supply that
20 information, but this is an announcement of a policy
21 change from a Children's Hospital in Sweden.

22 ATTORNEY BLOCK: Just for the record,
23 this doesn't seem to have a walk --- like --- it just
24 looks like words on a page without other sourcing on it.

1 ATTORNEY BARHAM: Your objection is
2 noted.

3 THE WITNESS: I mean without speaking to
4 the providence of the document, I have heard that there
5 was a change within the Swedish establishment in regards
6 to prepubertal youth or prepubertal youth.

7 BY ATTORNEY BARHAM:

8 Q. And what was your understanding of that change?

9 A. I would have to look through the specifics to
10 know for sure.

11 Q. What is your general understanding of the nature
12 of that change?

13 A. My general understanding was there was a pause
14 on some of the treatments, medical treatments available
15 for children with gender dysphoria.

16 Q. And by pause, at least according to this
17 document, it means that they had decided hormonal
18 treatments, i.e. puberty blocking and cross sex
19 hormones, will not be initiated in gender-dysphoric
20 patients under the age of 16.

21 Correct? First bullet point in executive
22 decisions.

23 A. Again, not knowing the providence of this
24 document, that's what this document says, yes.

1 Q. Are you aware that the United Kingdom's National
2 Health Service put an end to initiating hormone
3 treatment in new cases of individuals under 16?

4 ATTORNEY BLOCK: Objection to form and
5 foundation.

6 THE WITNESS: My understanding is that
7 it's under litigation right now and a final decision has
8 not been reached, but I could be wrong about that.

9 BY ATTORNEY BARHAM:

10 Q. Are you aware that that's at least a current
11 practice to put an end to initiating hormonal treatment
12 in new patients --- in new cases of individuals under
13 16?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: Can you repeat the
16 question?

17 BY ATTORNEY BARHAM:

18 Q. Are you aware that the United Kingdom's National
19 Services' current practice is to put an end to
20 initiating hormonal treatments in new cases of
21 individuals under 16?

22 ATTORNEY BLOCK: Objection to form and
23 foundation.

24 THE WITNESS: I do not have the NHS

1 policies in front of me, so I cannot speak to that.

2 ATTORNEY BARHAM: The document Exhibit
3 --- what number are on, 11.

4 LAW CLERK WILKINSON: 11, yes

5 BY ATTORNEY BARHAM:

6 Q. Exhibit 11 indicates, quote, the United
7 Kingdom's National Health Service put an end to
8 initiating hormonal treatment in new cases of
9 individuals under 16. Do you have any reason to believe
10 that that statement is inaccurate?

11 ATTORNEY BLOCK: Just objection that this
12 document came out at a certain time and so it's just not
13 clear what timeframe, you know, this question is
14 referring to. And just another objection to this
15 document. This appears to be a translation ---.

16 ATTORNEY BARHAM: Your objection is
17 noted. And we've already agreed that there are the
18 three objections, so I will ask you to cease the
19 speaking objections.

20 THE WITNESS: I have reason to doubt it.
21 Yes.

22 BY ATTORNEY BARHAM:

23 Q. What is your reason to doubt it?

24 A. My understanding is that there were legal

1 processes involved that have changed the landscape of
2 this care in the U.K.

3 Q. Are you aware of the National Health Service
4 reinitiating hormonal treatments in new cases of
5 individuals under 16?

6 A. I am unsure. That's where my doubt is.

7 Q. But you're aware that at one time they put an
8 end to those treatments for individuals under the age of
9 16?

10 A. Yes.

11 ATTORNEY BLOCK: Objection to form.

12 THE WITNESS: Yes.

13 ATTORNEY BARHAM: I'm going to show you
14 what we will mark as Exhibit-12. This is a document ---
15 an article by Lisa Nainggolan. I'm probably butchering
16 the last name.

17 LAW CLERK WILKINSON: Tab 93.

18 ATTORNEY BARHAM: Tab 93, entitled
19 Hormonal Treatment of Youth with Gender Dysphoria Stops
20 in Sweden.

21 ---

22 (Whereupon, Exhibit-12, Article by Lisa
23 Nainggolan, was marked for
24 identification.)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

BY ATTORNEY BARHAM:

Q. In the fourth paragraph it indicates that other centers in Sweden that treat gender dysphoria youth in Loom and Licopene will follow the lead of the ALB. Are you aware that those two clinics had made the same decision as the Astrid Lindgren Children's Hospital?

A. I am not.

ATTORNEY BARHAM: I'm going to show you what we will mark as Exhibit-4 --- I mean, I'm sorry Tab 94, Exhibit 13.

(Whereupon, Exhibit-13, Study, was marked for identification.)

BY ATTORNEY BARHAM:

Q. Are you aware that Finland has similarly reversed its course issuing new guidelines that allow puberty blockers only on a case by case basis after extensive psychiatric assessment?

ATTORNEY BLOCK: Objection to form. And can you give the witness and me a chance to see this document? Can the document be scrolled down?

THE WITNESS: What I can say about this

1 document is that I don't --- I've not heard of what
2 Cohere Finland is and how their recommendations impact
3 policies on the ground in Finland.

4 BY ATTORNEY BARHAM:

5 Q. So are you not familiar with Cohere as an
6 entity?

7 A. Correct.

8 Q. And that was a question. Are you?

9 A. I am not.

10 Q. Have you seen this document before today?

11 A. I have not.

12 ATTORNEY BARHAM: I'm going to show you
13 what we'll mark as Exhibit 14, and this will be Tab 95
14 for those watching at a distance.

15 ---

16 (Whereupon, Exhibit-14, Article Published
17 on Medscape.com, was marked for
18 identification.)

19 ---

20 BY ATTORNEY BARHAM:

21 Q. This is an article by Betsy McCall published on
22 Medscape.com on October 7th, 2021.

23 Is that correct?

24 A. Yes.

1 Q. If you look at the third paragraph from the
2 bottom. Ms. McCall reports that Scandinavian countries,
3 most notably Finland, once eager advocates for the
4 gender-affirmative approach, have pulled back and issued
5 new treatment guidelines in 2020, stating that
6 psychotherapy rather than gender reassignment should be
7 the first line of treatment for gender dysphoric youth.
8 Do you see that?

9 A. I see that.

10 Q. Do you agree with that approach?

11 ATTORNEY BLOCK: Objection to form.

12 THE WITNESS: Medscape is a popular press
13 forum for discussing issues and the language that is
14 used by this author implies to me that this is not
15 somebody who has a great deal of expertise or
16 understanding in this field.

17 BY ATTORNEY BARHAM:

18 Q. Do you agree with using psychotherapy rather
19 than gender reassignment as the first line of treatment
20 for gender dysphoric youth?

21 A. The term gender reassignment in and of itself is
22 not a meaningful term in this context, and so it's
23 unclear what this particular author is trying to get
24 across. And it's a false dichotomy that is being

1 positive that doesn't actually happen.

2 Q. Are you aware that Finland had issued new
3 treatment guidelines in 2020?

4 A. I don't recall the specifics of when guidelines
5 were recommended. But based upon the document that you
6 placed in front of me it seems to be yes. But I think
7 the description of those guidelines and what you put in
8 front of me as the Cohere guidelines, which again I'm
9 not sure what they actually represent in terms of their
10 policies, there are contradictions there.

11 ATTORNEY BLOCK: I'm sorry. I want to
12 put on the record this document about Finland also
13 appears to be a translation from the original by the
14 Society for Evidence Based Gender Medicine whose website
15 describes it as an unofficial translation. So I just
16 want to note that for the record.

17 ATTORNEY BARHAM: So noted. I'm going to
18 show you what we will mark as Exhibit 15, Tab 96.

19 ---

20 (Whereupon, Exhibit-15, Article in
21 National Health Service, was marked for
22 identification.)

23 ---

24 BY ATTORNEY BARHAM:

1 Q. And I will direct your attention to page 13.
2 This is a --- to identify the document for the record.
3 This is an Evidence Reviewed Gonadotrophin Releasing
4 Hormone Analogs for Children and Adolescents with Gender
5 Dysphoria, from the National Health Service in 2021 ---
6 or in 2020. On page 13, right at the beginning of the
7 conclusions section the authors indicate that the
8 results of studies that reported impact on the critical
9 outcomes of gender dysphoria and mental health and the
10 important outcomes of body image and psychosocial impact
11 in children and adolescents with gender dysphoria are a
12 very low certainty using modified grade. They suggest
13 little change with GnRH analogs from baseline to
14 follow-up. Do you see that?

15 A. I do not.

16 Q. First paragraph, under the conclusion.

17 A. Yes, I see that.

18 Q. Do you have any scientific basis for disputing
19 this conclusion?

20 ATTORNEY BLOCK: Objection. Let him read
21 the document.

22 THE WITNESS: I mean, without having seen
23 this before, I'm not sure what the scoping was for how
24 they defined which studies to include, which ones were

1 excluded, which would be required in a validated
2 metaanalysis type approach. So without a very specific
3 description of the methodology it's going to be hard for
4 me to make an educated statement.

5 BY ATTORNEY BARHAM:

6 Q. If you look at page three of the document, under
7 executive summary it highlights the nine observational
8 studies that were included in the evidence review.

9 A. Yeah, in a metaanalysis or even a systematic
10 review one of the processes that occurs is you define as
11 the authors what you are searching for, what are the
12 exclusionary and inclusionary criteria for each
13 individual study and a list of every single study that
14 was reviewed and why or why not it was included. That
15 is missing here, so it's --- I don't know how the
16 authors decided which ones to include or which ones not
17 to include, which makes it hard to draw a conclusion
18 from the report as it stands.

19 Q. Have you seen any other reports that suggest
20 that the evidence being discussed on page 13 under the
21 conclusions heading isn't anything higher than a very
22 low certainty using modified grade?

23 A. I'm not 100 percent familiar with modified grade
24 as a methodology, so I can't speak to how that would

1 apply to other studies.

2 Q. And the next paragraph the authors indicate that
3 studies found differences in outcome could represent
4 changes that are either a questionable clinical value or
5 the studies themselves are not reliable and changes
6 could be due to confounding bias or chance. Do you
7 agree that that is possible?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: Well, I agree that all
10 things are possible, that scientific literature is not
11 always 100 percent drawing any conclusions. But again,
12 without knowing specifically how they included what they
13 included or why they included what they included and why
14 they opt to remove others, it's not possible for me to
15 draw a specific conclusion from this.

16 BY ATTORNEY BARHAM:

17 Q. In paragraph 34 of your report you distinguish
18 Dr. Levine's approach to treating gender dysphoria as
19 --- or you describe it as gender identity conversion
20 model. Do you recall that?

21 A. Yes.

22 Q. In your view are there two approaches to
23 treating gender dysphoria in children and adolescents,
24 the gender-affirming model and the conversion therapy

1 model?

2 ATTORNEY BLOCK: Objection to form.

3 THE WITNESS: I would not agree with that
4 characterization.

5 BY ATTORNEY BARHAM:

6 Q. How many other approaches do you see? How do
7 you categorize the different approaches for treating
8 gender dysphoria in children and adolescents?

9 A. I don't agree with the premise, but there
10 specific defined treatment paradigms that are used. I
11 think there are --- there are elements of conversion
12 therapy as I referred to in my report. There are
13 elements of gender-affirming care and there is a
14 spectrum in between that.

15 Q. What are the elements --- what are the elements
16 of identity --- gender identity conversion model in your
17 mind?

18 A. I think the primary element as I understand it
19 in conversion therapy is a presupposition that a
20 transgender outcome is an inherently negative outcome
21 and that engagement or interventions should be put into
22 place in order to make that outcome the least likely as
23 possible.

24 Q. And in your mind gender-affirming care is care

1 that affirms that child's gender identity.

2 Correct?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: As I described earlier,
5 there are multiple components to how I would define
6 gender-affirming therapy.

7 ATTORNEY BARHAM: Let's go to Exhibit 16,
8 this will be Tab 97.

9 ---

10 (Whereupon, Exhibit-16, Article by
11 Roberto D'Angelo, was marked for
12 identification.)

13 ---

14 BY ATTORNEY BARHAM:

15 Q. This is an article by Roberto D'Angelo published
16 in 2020, entitled One Science Does Not Fit All. Are you
17 familiar with these authors?

18 A. Not personally, no.

19 Q. Are you familiar with them by reputation?

20 A. Looking at Dr. D'Angelo's footnotes, given that
21 he works for the Society for Evidence Based Gender
22 Medicine, then I might draw some conclusions from that.

23 Q. And what conclusions would you draw from that?

24 A. That there is a presupposition that transgender

1 identity is a negative outcome.

2 Q. And why would you draw that conclusion from that
3 association?

4 A. Based upon the description of the care on the
5 website. But that would be an assumption. I would
6 never do that on any individual basis for any of these
7 authors without knowing them.

8 Q. Beyond the association, do you have any reason
9 to doubt the scholarly integrity of the authors here?

10 A. I think you can't really talk about scholarly
11 integrity when it's a letter to the editor. It's not
12 the same --- same level of evidence as another study
13 would be.

14 Q. It's a letter to the editor that cites 37
15 different sources.

16 Is that correct? I'm looking at the last page.

17 A. The sources aren't numbered, so I don't know how
18 many sources it has, but ---.

19 ATTORNEY BLOCK: Let him look at it.

20 BY ATTORNEY BARHAM:

21 Q. The references at the end are numbered. Excuse
22 me. I apologize. I was looking at the wrong document.

23 A. There are 37 footnotes. I would assume that you
24 are correct on that.

1 Q. We are talking about this letter to the editor
2 --- let me clarify for the record because I was looking
3 at the wrong document prior to questioning for which I
4 apologize. This letter to the editor contains
5 approximately two pages of typed materials listing the
6 references that it uses.

7 Correct?

8 A. Yes, correct.

9 Q. Did you review this article when preparing your
10 report?

11 A. I did not.

12 Q. Did you review this article before today?

13 A. I have not.

14 Q. The article reviews the document published by
15 Turban, et al., in 2020, a study by Turban, et al, in
16 2020.

17 Is that correct?

18 A. It does.

19 ATTORNEY BLOCK: Objection to form.

20 BY ATTORNEY BARHAM:

21 Q. If you look at the last page, that article is
22 the same article that you cited in paragraph 34 of your
23 report.

24 Is that correct?

1 A. That's correct.

2 Q. This D'Angelo, et al. criticized Turban on
3 page one for his simplistic affirmation versus
4 conversion binary --- or I should state permeates his
5 narrative and establishes a foundation for their
6 analysis and conclusions. Do you see that on the first
7 page?

8 A. What page?

9 Q. The first page, second column, middle paragraph.

10 A. I see that, yes.

11 Q. These authors state the notion that all therapy
12 interventions for gender dysphoria can be categorically
13 classified into this simplistic binary betrays a
14 misunderstanding of the complexity of psychotherapy.
15 Would you agree with that statement?

16 ATTORNEY BLOCK: Objection to form and
17 asking him questions about an article he hasn't read.

18 THE WITNESS: The premise of that
19 statement implies a cognition on behalf of the authors
20 of that study that I don't think is necessarily
21 accurate. I don't think that the authors of the Turban
22 study would suggest that there is a simple binary of
23 therapy interventions.

24 BY ATTORNEY BARHAM:

1 Q. And you would also say there's not a simplistic
2 binary.

3 Is that correct?

4 A. That is correct.

5 Q. So in paragraph 34 of your report you're not
6 trying to draw a --- you're not trying to draw some sort
7 of dichotomy between Dr. Levine's approach and yours?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: It is less helpful for me
10 to describe it as identifying a dichotomy but really
11 more focused on the goals of treatment approach. And if
12 the goal of the treatment approach is a conversion type
13 goal, then I think there is a draw between that and the
14 standard of care of the affirmative model.

15 BY ATTORNEY BARHAM:

16 Q. So that in your view are there two different
17 treatment goals when treating gender dysphoria? We can
18 categorize treatment approaches by the goals, conversion
19 therapy versus the gender-affirming model that you have
20 outlined?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: The way I would describe
23 the goal of the gender-affirming model is to have a
24 healthy, resilient child whatever the gender identity

1 ends up being, whether that is a cisgender identity or
2 transgender identity. The difference between that and a
3 conversion therapy is again a presupposition that a
4 transgender identity is an inherently worse outcome
5 which is not focused on the overall mental health and
6 wellbeing of the child.

7 BY ATTORNEY BARHAM:

8 Q. I understand the distinction that you're making.
9 I'm trying to understand are there --- as we assess
10 different people's approaches to this area, can we
11 characterize them by the goals of their approach into a
12 gender-affirming model and a conversion therapy model
13 and those are basically two different camps.

14 Is that correct?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: We cannot.

17 BY ATTORNEY BARHAM:

18 Q. And in saying that I'm not trying to say that
19 therapeutic techniques belong in one or the other. I'm
20 just trying to say can we categorize treatment
21 approaches by the goals?

22 ATTORNEY BLOCK: Objection to form.

23 BY ATTORNEY BARHAM:

24 Q. Because that seems to be what you are doing in

1 paragraph 34 of your report.

2 A. There's a process versus an outcome question
3 that I'm just not understanding the distinction between
4 for as I'm defining conversion therapy here, it is a
5 specific goal that a transgender outcome is a negative
6 outcome. For gender-affirming therapy or interventions
7 there is no presupposed outcome that is better than
8 another other than building the mental health and
9 well-being of the child.

10 Q. Okay.

11 A. And there is many different ways of approaching
12 that question and intervening that are going to be
13 outside of the scope of a goal-based approach.

14 Q. It still sounds and again I'm just trying to
15 explore and understand what you're saying here. It
16 still sounds like there is one approach that has a goal
17 in your view of having the child return to comfort with
18 the child's natal sex and then there is another approach
19 that has a goal that says I don't care where you end up.
20 Is that fair to say?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: Again, I think it really
23 narrows down what's a highly complex question, so it's
24 really hard to give an answer to that. But if we define

1 conversion as approach one and everything else outside
2 of that, I can work with that if that is helpful for
3 having further discussion or asking more questions.

4 BY ATTORNEY BARHAM:

5 Q. Is that the way you would describe this
6 situation in the field at present?

7 A. It is not the way I would describe the situation
8 in the field.

9 Q. On page five of this article ---.

10 ATTORNEY BLOCK: I'm sorry, which
11 article?

12 ATTORNEY BARHAM: On Tab 97 of
13 Exhibit 16. Dr. D'Angelo's article.

14 BY ATTORNEY BARHAM:

15 Q. It sounds to me like you are rejecting what
16 these authors describe as a conflation of ethical
17 non-affirming psychotherapy and conversion therapy, next
18 to the last paragraph on the page.

19 ATTORNEY BLOCK: Objection. Please give
20 him time to read the page.

21 THE WITNESS: I've never seen of or heard
22 a definition for ethical non-affirmative psychotherapy,
23 so I don't know what that means.

24 BY ATTORNEY BARHAM:

1 Q. Is it your position that there is no such thing?

2 A. I have never heard of such a thing.

3 Q. On page six, in the first column, the authors
4 write, in fact, some homophobic societies and indeed
5 families that reject homosexuality among their children
6 have embraced the affirmative biomedical pathway, which
7 poses questions as to whether, quote, affirmative care
8 in some cases in some instances serve the role of gay
9 conversion therapy. Do you believe that that's a
10 legitimate concern?

11 A. I do not.

12 Q. Why not?

13 A. As I mentioned before, affirmative care is not
14 presupposed any one specific outcome.

15 Q. Do you think that someone can have a concern
16 that affirmative care could serve the role regardless of
17 its dole, serve the role of gay conversion therapy?

18 ATTORNEY BLOCK: Objection to form.

19 THE WITNESS: Well, the authors appear to
20 have that concern. It is not a concern that has been
21 borne out by the literature in my clinical experience.

22 BY ATTORNEY BARHAM:

23 Q. Do you believe that the authors are reasonable
24 in having that concern?

1 A. I can't speak to what the authors' motivations
2 are for writing this. I do not know.

3 Q. Based on your knowledge of the field, do you
4 believe that that's a reasonable concern?

5 A. I do not.

6 Q. Why not?

7 A. Because understanding the overlap and the
8 interaction between gender identity and sexuality and
9 sexual orientation is a part of the assessment process
10 in affirming care.

11 Q. At the bottom of page one the authors write, if
12 anything other than affirmation is viewed as GICE ---.

13 A. What page is that?

14 Q. On page six, I'm sorry. Same page you were on
15 with the gay affirmative therapy or gay conversion
16 therapy. The last paragraph in column one of page six.
17 If anything other than affirmation is viewed as GICE, it
18 follows that the provision of psychotherapy in these
19 clinical scenarios can be seen as harmful conversion
20 efforts. If these therapeutic efforts do not aim to
21 convert or consolidate an identity but instead aim to
22 help individuals gain a deeper understanding of their
23 discomfort with themselves, the factors that have
24 contributed to their distress and their motivations for

1 seeking transition. Is it your position that there are
2 no therapeutic interventions that do not aim to convert
3 or consolidate an identity?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: What I would say is that
6 helping individuals gain a deeper understanding of their
7 discomfort with themselves, the factors contributing to
8 their distress and their motivations for seeking
9 transition is a vital and inherent part of
10 gender-affirming care.

11 BY ATTORNEY BARHAM:

12 Q. But a moment ago you indicated that you were not
13 aware of any ethical non-affirmative psychotherapy?

14 A. That is not a phrase that I have heard or have
15 heard described. What the passage that you are
16 referring to describes is a very typical process
17 involved in any kind of standard of care around anything
18 really is understanding motivations and understanding
19 distress. There is nothing --- there is nothing novel
20 about that description of care that is not already under
21 the umbrella of affirming care.

22 Q. And a little bit later in that paragraph, I
23 believe at the top of column two of page six, the
24 authors right both conversion and affirmative therapy

1 efforts carry the risk of undue influence potentially
2 compromising patient autonomy. Do you agree that that
3 is a possibility?

4 A. Again, I'm not sure what the authors are
5 referring to when they say affirmation therapy efforts
6 because what they're describing as ethical,
7 non-affirmative interventions falls to me under the
8 clear rubric of affirming care, so I don't know what
9 they mean by this.

10 Q. Okay.

11 In paragraph 35 of your report you indicate ---
12 you stated research indicates that social transitioning
13 significantly improves the mental health of transgender
14 young people.

15 Is that correct?

16 A. Yes.

17 ATTORNEY BARHAM: And I'm going to show
18 you what we will mark as Exhibit 17. This is Tab 118
19 for those following from a distance. This is a study by
20 Gibson, et al. published in 2021.

21 ---

22 (Whereupon, Exhibit 17, Study by Gibson,
23 et al., was marked for identification.)

24 ---

1 BY ATTORNEY BARHAM:

2 Q. You've cited this article in footnote nine of
3 your report.

4 Is that correct?

5 A. Let me just double check. I believe so. Yes.

6 Q. Under methods on page one of Exhibit-17 it
7 indicates this a cross-sectional study.

8 Is that correct?

9 A. That is correct.

10 Q. Can cross-sectional studies be used to
11 demonstrate causation?

12 A. Not on their own, no.

13 Q. So this study does not show that social
14 transitions caused any improvement in mental health.

15 Correct?

16 A. This study demonstrated that there was a
17 correlation between improved mental health and social
18 transition.

19 Q. So it did not show causation.

20 Is that correct?

21 A. It did not show causation.

22 Q. I'm going to show you Exhibit 9. Let's go back
23 to Exhibit 9.

24 LAW CLERK WILKINSON: Tab 117.

1 BY ATTORNEY BARHAM:

2 Q. Tab 117. This is the article by Lily Durwood,
3 et al. published in 2017. You cited this article also
4 in footnote nine of your report.

5 Is that correct?

6 A. That is correct.

7 Q. And we have previously discussed how this
8 article reports what children and parents said about the
9 children's mental health.

10 Is that correct?

11 A. That is correct.

12 Q. Really a self report.

13 Correct?

14 A. I think we went through that earlier. It was
15 not just a self report. These were interview led
16 evaluations.

17 Q. But an interview led self report.

18 Correct?

19 A. There were also parent reports that were ---.

20 Q. And so self reports of children, parental
21 reports about their children.

22 Correct?

23 A. Correct.

24 Q. Okay.

1 And then in footnote nine you also cite a study
2 by Olson, et al. in 2016, footnote nine of your report.

3 Correct?

4 A. That is correct.

5 Q. And in footnote nine you indicate that alleged
6 statistical errors in that article have already been
7 corrected in 2018.

8 Correct?

9 A. Correct.

10 Q. And for that assertion you cite a study by
11 Olson, et al. in 2018.

12 Is that correct?

13 A. I don't see that.

14 ATTORNEY BLOCK: Objection. Where are
15 you at?

16 THE WITNESS: I don't see it. If you can
17 point to me where that is.

18 BY ATTORNEY BARHAM:

19 Q. Footnote nine, on page 11, small statistical
20 errors in Olson 2016 had already been corrected in 2018,
21 see Olson, et al., 2018, mental health of transgender
22 student who are supported in their identity throughout.

23 A. Yes.

24 Q. Is that correct?

1	A. Yes.
---	---------

2 ATTORNEY BARHAM: I'm going to show you
3 what we are going to mark as Exhibit 18. This will be
4 tab 119.

5 | -----

6 (Whereupon, Exhibit-18, Errata Sheet, was
7 marked for identification.)

8 | -----

9 BY ATTORNEY BARHAM:

10 Q. This is the errata sheet that you cited in
11 footnote nine of your report.

12 | Is that correct?

13 | A. That is correct.

14 Q. The only change in this 2018 article is the
15 highlight and missing common from the 2016 article.

16 | Is that correct?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: Yes.

19 BY ATTORNEY BARHAM:

20 Q. In paragraph 40 of your report you say that
21 studies have repeatedly documented puberty blocking
22 medication and gender-affirming hormone therapy are
23 associated with mental health benefits in both the short
24 and long term.

1 Is that correct?

2 A. That is correct.

3 Q. And the studies that you're citing for that
4 assertion are those listed in footnote 14 of your
5 report.

6 Correct?

7 A. That is correct.

8 Q. Are there any others that you are referencing?

9 A. Those are the only that I'm referencing.

10 Q. In paragraph 41 of your report you claim that
11 Dr. Cantor fails to discuss many of the studies
12 documenting the benefits of puberty blocking medication.
13 Which of the studies in footnote 14 did he fail to
14 discuss?

15 A. I would need to review Dr. Cantor's report to
16 know specifically.

17 Q. Do you recall now which ones he failed to
18 discuss?

19 A. I do not.

20 ATTORNEY BARHAM: All right. I'm going
21 to show you what we will mark as Exhibit-19, and this is
22 Tab 98.

23 ---

24 (Whereupon, Exhibit-19, Article by

1 Tordoff, et al., was marked for
2 identification.)

3 ---

4 BY ATTORNEY BARHAM:

5 Q. This is an article by Tordoff, et al, published
6 in 2022, entitled Mental Health Outcomes in Transgender
7 and Non-Binary Youth Receiving Gender-Affirming Care.
8 This is one of the studies that you cited in footnote 14
9 of your report?

10 A. That is correct.

11 Q. According to table one on page five of this
12 report 65 percent of the participants were also
13 receiving mental health therapy.

14 Is that correct?

15 A. That is correct.

16 Q. So it's not possible to determine how much of
17 the improvement was due to puberty blocking medication
18 and gender-affirming hormone therapy and how much was
19 due to the mental health therapy.

20 Correct?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: There is a lot of questions
23 in that one singular question about study design and
24 what we know about the history of transgender health

1 outcomes prior to the existence of gender-affirming
2 care. As this study is designed, it is not designed in
3 such a way to be able to specifically keep that apart.

4 ATTORNEY BARHAM: All right.

5 I'm going to show you what we will mark
6 as Exhibit-20, and this will be Tab 99.

7 ---

8 (Whereupon, Exhibit-20, Article by Amy
9 Green, et al., was marked for
10 identification.)

11 ---

12 BY ATTORNEY BARHAM:

13 Q. This is the second article. This is an article
14 by Amy Green entitled ---- it says et al. entitled
15 Association of Gender Affirming Hormone Therapy with
16 Depression, Thoughts of Suicide and Attempted Suicide
17 Among Transgender and Nonbinary Youth published in 2021.
18 This is the second article that you cited in footnote 14
19 of your report.

20 Is that correct?

21 A. That is correct.

22 Q. On page six of this report, column two, the
23 authors indicate that causation cannot be inferred due
24 to this study's cross-sectional design.

1 Correct?

2 A. That is correct.

3 Q. This study also does not prove that puberty
4 blocking medication and gender-affirming hormone therapy
5 caused any improvements.

6 Correct?

7 ATTORNEY BLOCK: Objection to form.

8 THE WITNESS: This study was not designed
9 to show a causal outcome, no.

10 ATTORNEY BARHAM: Let's go to Exhibit 21,
11 this will be Tab 100.

12 ---

13 (Whereupon, Exhibit-21, Article by
14 Turban, et al., was marked for
15 identification.)

16 ---

17 BY ATTORNEY BARHAM:

18 Q. This is an article by Turban, et al. published
19 in 2020 entitled Pubertal Risks for Transgender Youth
20 and Risks of Suicide Ideation --- Suicidal Ideation?

21 ATTORNEY BLOCK: Objection to misreading
22 the name of the study.

23 BY ATTORNEY BARHAM:

24 Q. This is the third article that you cited in

1 footnote 13 of your report.

2 Is that correct?

3 A. That is correct.

4 Q. And on page seven of this article the authors
5 also indicate that limitations include the
6 cross-sectional --- the study's cross-sectional design,
7 which does not allow for determination of causation.

8 Is that correct?

9 A. That is correct.

10 Q. So this study does not prove that puberty
11 blocking medication and gender affirming hormone therapy
12 caused any improvements.

13 Correct?

14 A. This study was not designed to demonstrate
15 causation.

16 ATTORNEY BARHAM: I'm going to show you
17 what we will mark as Exhibit-22. This is an article by
18 Achille, et al. entitled Longitudinal Impact of Gender
19 Affirming Endocrine Intervention on Mental Health and
20 Well-being of Transgender Youths, Preliminary Results
21 published in 2020.

22 ---

23 (Whereupon, Exhibit-22, Article by

24 Achille, et al., was marked for

1 identification.)

2 ---

3 BY ATTORNEY BARHAM:

4 Q. You also cited this article in footnote 14 of
5 your report.

6 Is that correct?

7 A. Yes, I did.

8 Q. And on page two of this report, the bottom of
9 the first column, the authors write that most
10 subjects --- quote, most subjects were followed by
11 mental health professionals, closed quote, and quote,
12 those that were not were encouraged to see a mental
13 health professional.

14 Correct?

15 A. That is correct.

16 Q. And on page three, the first column, the authors
17 say that after statistically adjusting for psychiatric
18 medication and engagement in counseling, quote, most
19 predictors did not reach statistical significance.

20 Is that correct?

21 A. Where are you?

22 Q. Page three, column one, under regression
23 analysis.

24 A. Correct.

1 ATTORNEY BARHAM: I'm going to show you
2 what we will mark as Exhibit-23, this is Tab 102.

3 ---

4 (Whereupon, Exhibit-23, Article by Kuper,
5 et al., was marked for identification.)

6 ---

7 BY ATTORNEY BARHAM:

8 Q. This is an article by Kuper, et al. published in
9 2020, entitled Body Dissatisfaction and Mental Health
10 Outcomes of Youth on Gender Affirming Hormone Therapy.
11 On page six --- let me rephrase that for the record.
12 You cited this article in footnote 14 of your report.

13 Is that correct?

14 A. That is correct.

15 Q. According to Table 2 on page six none of the
16 results for those receiving puberty suppression were
17 statistically significant.

18 Correct?

19 A. I need a few minutes.

20 Q. Take your time.

21 A. As I read the bottom of that table, there are a
22 number of analyses that reached statistical
23 significance.

24 Q. But if you look at the lines for each one under

1 each of the scores, body dissatisfaction, depressive
2 symptoms, depressive symptoms QIDS, anxiety symptoms,
3 panic symptoms, generalized anxiety symptoms, social
4 anxiety symptoms, separation anxiety symptoms, school
5 avoidance symptoms, the lines marked puberty suppression
6 have no superscript on them.

7 Is that correct?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: That is correct.

10 BY ATTORNEY BARHAM:

11 Q. So none of those --- none of the specific
12 findings regarding individuals on puberty suppression
13 only were statistically significant.

14 Is that correct?

15 A. None of them were statistically significant as
16 measured by their reports.

17 ATTORNEY BARHAM: I'm going to show you
18 what we will mark as Exhibit-24. This will be Tab 103.

19 ---

20 (Whereupon, Exhibit-24, Article by van
21 der Miesen, et al., marked for
22 identification.)

23 ---

24 BY ATTORNEY BARHAM:

1 Q. This is an article by van der Miesen, et al.,
2 published in 2020 entitled Psychological Functioning in
3 Transgender Adolescents Before and After Gender
4 Affirmative Care Compared with Cisgender General
5 Population of Peers. You cited this article in footnote
6 14 of your report.

7 Is that correct?

8 A. That is correct.

9 Q. The authors on page five, in column two, the
10 authors of this study ---.

11 A. What page?

12 Q. Page five.

13 A. I have that in the 700s.

14 Q. Oh 703, sorry. 703. The fifth page, but it's
15 paginated 703. The authors of this study indicate that,
16 quote, due to its cross-sectional design, the present
17 study cannot provide evidence about the direct benefits
18 of puberty suppression over time and long-term mental
19 health outcomes?

20 Correct?

21 A. I don't see where that is.

22 Q. Next to the last paragraph in the second column.
23 The third and most important --- skipping the
24 cross-sectional design of this study different

1 participants in the groups before and after puberty
2 suppression may potentially limit the results?

3 A. Yes, I see that.

4 Q. The present study can therefore not provide
5 evidence about the direct benefits of puberty
6 suppression over time and the long-term mental health
7 outcomes.

8 Is that correct?

9 A. That is correct.

10 Q. So the authors of this study indicate that
11 conclusions about the long-term benefits of puberty
12 suppression should thus be made with extreme caution,
13 meaning prospective long-term follow-up studies with
14 repeated measured design of individuals being followed
15 over time to confirm.

16 Is that correct?

17 A. That is correct.

18 ATTORNEY BARHAM: I'm going to show you
19 what we will mark as Exhibit-25. This will be Tab 104.

20 ---

21 (Whereupon, Exhibit-25, Article by de
22 Vries, was marked for identification.)

23 ---

24 BY ATTORNEY BARHAM:

1 Q. This is an article by van der Miesen --- or I
2 mean De Vries, et al --- excuse me, De Vries, et al.,
3 2014, Young Adult Psychosocial Outcome After Puberty
4 Suppression and Gender Reassignment. This is the last
5 article you cite in footnote 14 of your report.

6 Is that correct?

7 A. That is correct.

8 Q. At the Dutch clinic patients who receive puberty
9 blockers also receive psychotherapy.

10 Is that correct?

11 A. That is correct.

12 Q. So again, there is no way to determine how much
13 of the improvement reflected in this study is due to the
14 puberty blockers and how much is due to the
15 psychotherapy.

16 Correct?

17 ATTORNEY BLOCK: Objection to the form.

18 THE WITNESS: Let me restate my response
19 to the previous question. The Dutch clinic always
20 recommends participation in therapy. I'm not a
21 100 percent certain that every participant participated
22 in the therapy as directed.

23 BY ATTORNEY BARHAM:

24 Q. For the most part, the Dutch model combined

1 psychotherapy with puberty blockers.

2 Correct?

3 ATTORNEY BLOCK: Objection.

4 THE WITNESS: That is correct. And may I
5 state that I think that is part of the reason that the
6 van der Miesen study is quite important because it does
7 start to look at the impact of being on the wait list
8 and the impacts of just getting psychotherapy alone
9 versus access to puberty suppression and/or hormones.

10 ATTORNEY BARHAM: I'm going to show you
11 what we're going to mark as Exhibit-26. Tab 105.

12 ---

13 (Whereupon, Exhibit-26, Article, was
14 marked for identification.)

15 ---

16 BY ATTORNEY BARHAM:

17 Q. This is an article by Michael Biggs published in
18 2020, Gender Dysphoria and Psychological Functioning in
19 Adolescents Treated with GnRHa. Are you familiar with
20 this study?

21 ATTORNEY BLOCK: Objection,
22 mischaracterizes the document.

23 BY ATTORNEY BARHAM:

24 Q. Are you familiar with this letter to the editor?

1 A. I have not read this letter to the editor.

2 Q. If you look at bottom of page one continuing
3 onto page two, the author writes an additional
4 complication with this treatment is that the Dutch model
5 combines GnRHa with psychological support so the two
6 effects are inevitably conflated. Do agree with that
7 statement?

8 A. I do not.

9 Q. Why?

10 A. Use of GnRH logs for this kind of intervention
11 were first used in 1999. So every --- every transgender
12 person prior to 1999 had no access to this kind of
13 treatment. Between 1999 and probably about 2014 these
14 medications were not widely available and so unavailable
15 for use for most people. So we have the clinical
16 experience of adults, talking retrospectively, about
17 their experiences as well as the patients that we have
18 treated that did versus did not have access to these
19 interventions. So we have both clinical experience and
20 some retrospective data that looks at this question
21 specifically.

22 Q. Can retrospective data demonstrate causation?

23 A. In some cases it can.

24 Q. But retrospective data is subject to recall by

1 us in other drawbacks that undermine its reliability.

2 Correct?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: It depends upon the type of
5 data that is being calculated.

6 BY ATTORNEY BARHAM:

7 Q. Why do you mean by that?

8 A. If it is qualitative interview data, yes, there
9 is retrospective data that reviews contemporary
10 documentation and charts, lab results, imaging results,
11 et cetera. That is less confounded by that kind of
12 bias.

13 Q. When we are talking about people recalling their
14 experiences before hormone therapy was available that
15 would be the qualitative type of data.

16 Correct?

17 A. Correct. And when analyzing that data you have
18 to take that into account.

19 Q. So that still doesn't help me understand why you
20 disagree with that statement because the Dutch model
21 combines hormones with psychosocial --- psychological
22 support, the two effects are inevitably conflated?

23 A. We have a long history of people receiving
24 psychological support alone. And with the addition of

1 these interventions and this model of care, outcomes
2 improve with specific measures around gender dysphoria.

3 Q. Over that time the psychological support would
4 have evolved as more understanding was gained.

5 Correct?

6 A. One would hope, yes.

7 ATTORNEY BLOCK: Objection to form.

8 BY ATTORNEY BARNHAM:

9 Q. But for the individuals who receive treatment
10 under the Dutch model, receiving both the hormones and
11 the psychological support, it's impossible to determine
12 how much improvement was due to the psychological
13 support and how much was due to the hormones.

14 Correct?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: There has not been a study
17 that has sought to identify the specific percentage of
18 impact of those two.

19 ATTORNEY BARHAM: All right.

20 I'm going to show you what we will mark
21 as Exhibit 27.

22 ---

23 (Whereupon, Exhibit 27, Article, was
24 marked for identification.)

1

2

BY ATTORNEY BARHAM:

3

Q. Tab 106. This is an article by Costa, et al.

4

In 2015 Psychological Support, Puberty Expression and

5

Psychosocial Functioning in Adolescents with Gender

6

Dysphoria.

7

Is that correct?

8

A. That is correct.

9

Q. You cite this article in footnote 14 of your

10

report.

11

Is that correct?

12

A. That's correct.

13

Q. Now, in this study there were two groups of

14

adolescents, those who receive both puberty --- I mean,

15

both therapy and puberty blockers at the outset and

16

those who received just therapy at the outset.

17

Correct?

18

A. I'll need a minute to refresh myself.

19

Q. Sure. And I'm referencing pages 228, the second

20

column over to 229, the top of the first column.

21

A. That's correct.

22

Q. And on page 2211 going over to 2212, the

23

author's note that the difference between the

24

immediately eligible group and the delayed eligible

1 group failed to reach significance.

2 Correct?

3 A. So as I read this, immediately eligible group
4 who had a higher in psychosocial functioning did not
5 show any significant improvement after 12 months, but
6 after 12 months there was a statistical difference.

7 Q. Then it says finally, even if the end or
8 follow-up study, plan three, immediately eligible group
9 had a five point higher CGAS score than the delayed
10 eligible group, this difference failed to reach
11 significance.

12 Correct?

13 A. That's correct. What I have to point out there,
14 is CGAS is the children's global assessment scale, and
15 not a measure of gender dysphoria or quality of life or
16 distress in body.

17 Q. Is it a measure of a child's mental health?

18 ATTORNEY BLOCK: Objection.

19 THE WITNESS: It is a rough and very
20 precise measure of general functioning.

21 BY ATTORNEY BARHAM:

22 Q. But it is the scale that this study was using.

23 Correct?

24 A. That is correct.

1 ATTORNEY BARHAM: Let's go to tab 28.

2 ---

3 (Whereupon, Exhibit 28, Article by
4 Edwards-Leeper, was marked for
5 identification.)

6 ---

7 THE WITNESS:

8 And to clarify the CGAS is something that
9 is clinician rated of remedy objective criteria.

10 BY ATTORNEY BARHAM:

11 Q. Do you want to take a break?

12 A. In a few minutes if that's okay.

13 Q. Are you aware of Dr. Edwards-Leeper's reputation
14 in the field?

15 A. I am.

16 Q. Are you personally acquainted with Dr.
17 Edwards-Leeper?

18 A. I am.

19 Q. Have the two of you worked together in the
20 American Psychiatric Academics Association?

21 A. We have not worked together through the American
22 Psychiatric Association. Dr. Edwards-Leeper is a
23 psychologist.

24 Q. She served as a member of the task force to

1 develop practice guidelines for working with transgender
2 individuals? Have you served in a similar capacity with
3 the American Psychiatric Association?

4 A. I have. And we both worked together on the
5 WPATH standards of care provision.

6 Q. You anticipated my next question. So you would
7 agree that Dr. Edwards-Leeper is considered an
8 international expert in this area.

9 Correct?

10 A. Yes. Dr. Edwards-Leeper is a complicated figure
11 right now, but yes, she has a lot of expertise.

12 ATTORNEY BARHAM: I want to show you what
13 we will mark as Exhibit 29. This is Tab 29.

14 --

15 (Whereupon, Exhibit 29, Article by
16 Edwards-Leeper, was marked for
17 identification.)

18 ---

19 ATTORNEY BLOCK: I imagine you have a lot
20 of questions about this next document, and I just want
21 to make sure the witness has a chance to have a bathroom
22 break if it's going to go on for ten minutes or more.

23 ATTORNEY BARHAM: I have no objection to
24 that.

1 THE WITNESS: Five minutes.

2 ATTORNEY BARHAM: We will take five
3 minutes.

4 VIDEOGRAPHER: Going off the record. The
5 time is 12:12 p.m.

6 | OFF VIDEO

7 | -----

8 | (WHEREUPON, A SHORT BREAK WAS TAKEN.)

9 | -----

10 | ON VIDEO

11 VIDEOGRAPHER: We are back on the record

12 the current time reads 12:21 p.m.

13 | BY ATTORNEY BARHAM:

14 Q. A moment ago we were discussing Dr.
15 Edwards-Leeper and you commented that she is a
16 complicated individual.

17 | What did you mean by that?

18 A. What I mean is that she has published some
19 things in popular press that have led me to be talking
20 about her here.

21 Q. And would one of those be the document before
22 you Exhibit 29?

23 | A. That is correct.

24 Q. This is an article published in the Washington

1 Post by Dr. Edwards-Leeper and Dr. Anderson.

2 Is that correct?

3 A. That is correct.

4 Q. What is it --- are there any other publications
5 that Dr. Edwards-Leeper has written recently that caused
6 you to describe her as a complicated figure?

7 A. No, no.

8 Q. So just this one article.

9 Is that correct?

10 A. Yes.

11 Q. Are you familiar with Dr. Anderson?

12 A. I am.

13 Q. She is a clinical psychiatrist?

14 A. She is a psychologist.

15 Q. A psychologist. And Dr. Anderson has been
16 working with transgender youth for a long time.

17 Is that correct?

18 A. I'm not a hundred percent familiar with Dr.
19 Anderson's history, I don't know.

20 Q. Was she in the field before you?

21 A. I don't know.

22 Q. Dr. Anderson is also a transgender.

23 Is that correct?

24 A. That is correct.

1 Q. Dr. Anderson is a member of the American
2 Psychological Association Committee tasked with writing
3 guidelines and working with transgender individuals.

4 Is that correct?

5 A. I do not know.

6 Q. Dr. Anderson is a former president of the U.S.
7 Professional Association for Transgender Health.

8 Is that correct?

9 A. That is correct.

10 Q. Dr. Anderson is a former board member for the
11 World Professional Association for Transgender Health.

12 Correct?

13 A. I'm not sure.

14 Q. Beyond the committee assignments listed on
15 page two of your CV have you held any committee
16 assignments for the USPATH or WPATH Organizations?

17 A. Not additional committee assignments than WPATH
18 or USPATH, no.

19 Q. In this copy published in the Washington Post
20 Dr. Edwards-Leeper and Dr. Anderson summarizes a
21 situation of a 13-year old natal girl with no prior
22 history of gender dysphoria. Some issues of sexual
23 assault and depression and then an abrupt announcement
24 of this child of transgender identity.

1 Does that summarize the scenario they outline?

2 A. That is the scenario they outlined.

3 ATTORNEY BLOCK: Objection to form.

4 BY ATTORNEY BARNHAM:

5 Q. What percent of your patients first present as a
6 team without a prior gender dysphoria diagnosis?

7 A. Well, first I just want to address the scenario
8 with Patricia, this is a popular press article, so I
9 have no idea if Patricia is a real person or an amalgam.

10 Q. Understood.

11 A. I hope it's an amalgam, because it would be
12 unethical to not have consent to publish this story.
13 Whether or not a child has a diagnosis of gender
14 dysphoria before they come to see me is dependent upon
15 if they've had previous evaluations, so it's dependent.
16 I don't have a specific number for you.

17 Q. In general, how many of your patients first
18 present as a team versus first presenting as a child?

19 A. That is very different, depending upon which
20 cite that I was practicing at. So in New York I saw
21 more prepubertal youth than I do in Chicago.

22 Q. So in New York, what percent of your patients
23 first presented as adolescents versus children?

24 A. I think I answered that question earlier. If I

1 remember it was 25 percent of the 75 percent.

2 Q. And in Chicago how many --- what percentage of
3 your patients present as adolescents versus as teen?

4 A. Probably 90 percent during adolescence.

5 Q. And are those all adolescents who first
6 presented as adolescents or did they first present with
7 gender dysphoria as a child?

8 A. It's a combination of both.

9 Q. So of your adolescent patients how many
10 presented first as an adolescent, and how many presented
11 as a child?

12 A. I don't have that information in front of me.

13 Q. Do you have a general ballpark idea?

14 A. No, I mean, the question --- I guess what I'm
15 struggling with is that there are a lot of adolescents
16 who I see who presented the first as adolescent, but
17 have clear symptoms of gender dysphoria going back to
18 childhood. So I'm not sure how to characterize those
19 children in your question.

20 Q. What percent of the patients that present
21 themselves to you first as an adolescent are natal
22 female?

23 ATTORNEY BLOCK: Objection to
24 terminology.

1 THE WITNESS: I would say in the clinic
2 where I'm practicing, currently certainly over half of
3 the children presenting in adolescence for the first
4 time are assigned female at birth.

5 BY ATTORNEY BARHAM:

6 Q. And in New York, what percent of the patients
7 that presented to you first as an adolescent or natal
8 female?

9 A. In New York it was more even split between those
10 assigned female and those assigned male at birth.

11 Q. And here when you say it's more than 50 percent
12 are we talking 75 percent, we're talking 80 percent,
13 90 percent?

14 A. I don't have that information in front of me, so
15 I couldn't tell you specifically. It would be a guess.

16 Q. Do you have a range?

17 A. I don't. I don't. More than 50 is the closest
18 that I can get right now.

19 Q. More than 75 percent?

20 A. Probably not, no.

21 Q. So somewhere between 50 and 75?

22 A. That's a good guess.

23 Q. What proportion of teen girls presenting at your
24 clinic have suffered sexual assault or abuse of any

1 sort?

2 A. So if we're talking assigned females at birth,
3 is that what you mean?

4 Q. Yes. Natal females.

5 A. Between one out four and one out of eight
6 assigned females at birth who do not identify as
7 transgender have exposure to sexual assault and trauma f
8 some kind. What we know from the literature is that
9 rates of sexual assault and sexual abuse of transgender
10 youth is higher than that and my patients are relatively
11 similar to that, so probably in the order of 25 to
12 30 percent.

13 Q. What policies do you have in place to ensure
14 adequate counseling and therapy for that trauma before
15 making any decisions regarding hormones?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: Assessing co-occurring
18 psychiatric disorders or stressors or traumas is an
19 inherent part of any assessment.

20 BY ATTORNEY BARHAM:

21 Q. Beyond just it being an inherent part of any
22 assessment, do you have any other policies or standards
23 that you use to ensure that the trauma is addressed
24 before making decisions regarding hormones?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: I mean, I don't have a
3 written down policy. Incorporating understanding of
4 trauma is always going to be an important part of any
5 informed assessment prior to moving forward with an
6 intervention.

7 BY ATTORNEY BARHAM:

8 Q. Do you agree or disagree that before prescribing
9 hormones to a teen girl who has suffered sexual abuse or
10 depression, medical professionals have a responsibility
11 to confirm that the patient has received a thorough
12 mental health assessment, including investigating how
13 other mental health issues and any other changes in her
14 life might be contributing to her desire are perceived
15 transgender identification?

16 ATTORNEY BLOCK: Objection to form and
17 terminology.

18 THE WITNESS: So for any child regardless
19 of gender, who we are recommending a medical or surgical
20 intervention, we are assessing for the presence of
21 gender dysphoria, the presence of co-occurring
22 psychiatric disorders and their impact on that diagnosis
23 or the capacity to consent to treatment, and a clear
24 understanding of the risks, benefits and alternatives of

1 whatever that intervention may be.

2 BY ATTORNEY BARHAM:

3 Q. So then --- and that would include investigating
4 how other mental health issues and other changes in her
5 life might be contributing to her desire or perceived
6 transgender identification?

7 A. That is correct.

8 ATTORNEY BLOCK: Objection to terminology
9 and pronouns.

10 BY ATTORNEY BARHAM:

11 Q. Do you agree or disagree that the standards of
12 care recommend mental support and comprehensive
13 assessment for all dysphoric youth before starting
14 medical interventions?

15 A. I would agree that the current recommendations,
16 which are in the process of being updated recommend that
17 a mental health assessment be in place. And it's not a
18 mandate that psychotherapy is a requirement prior to
19 initiation of medical care for gender dysphoria, and it
20 is not indicated for every patient.

21 Q. And that's partly because the standards of care
22 are guidelines not mandates.

23 Correct?

24 A. It's mostly because of the indications for the

1 patient's best interest that psychotherapy is not a
2 requirement for folks who are otherwise doing well.

3 Q. But it's also true that the standards of care
4 are guidelines not mandates.

5 Correct?

6 A. That is correct. They are guidelines.

7 Q. On page two of this article the author is ---
8 and by this article I'm referring to tab 29. The author
9 has indicated that a study of ten pediatric gender
10 clinics in Canada found that half do not require
11 psychological assessment before initiating puberty
12 blockers or hormones.

13 Is that your policy?

14 A. Where is this in the article? I don't see it.

15 Q. The bottom of page two?

16 A. What I want to emphasize is this is an opt ed
17 and a popular press outlet and not a study. So I have
18 no idea where they gathered their information about this
19 or the accuracy of the statement, nor do I know what the
20 authors meant by a psychological assessment.

21 Q. I understand. I did not mean to imply that
22 this article Exhibit --- tap 29 is a study. I was
23 merely quoting the authors, that a study of ten
24 pediatric gender clinics found that half do not require

1 psychological assessment before initiating puberty
2 blockers or hormones. My question to you is, is that
3 your policy?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: Again, I can't speak to the
6 accuracy of Dr. Edwards-Leeper and Dr. Anderson's
7 description of a study that I haven't seen.

8 BY ATTORNEY BARHAM:

9 Q. I'm not asking you to. I'm asking do you have
10 --- is it your policy at your clinic that you do not
11 require psychological assessments before initiating
12 puberty blockers for hormones?

13 A. We require psychological assessments prior to
14 initiation, yes.

15 ATTORNEY TRYON: Travis, it's Dave Tryon.
16 You referred to this as Tab 29, I believe you mean
17 Exhibit 29. Is that right?

18 ATTORNEY BARHAM: It's both Exhibit 29
19 and Tab 29.

20 BY ATTORNEY BARHAM:

21 Q. When patients come to you referred by a
22 pediatrician or counselor with no expertise in gender
23 dysphoria assessment or diagnosis, what policies do you
24 have to ensure that the patients receive full and

1 adequate course of mental healthcare before prescribing
2 life altering hormones?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: As a mental health
5 professional I'm not the person who is prescribing those
6 treatments.

7 BY ATTORNEY BARHAM:

8 Q. Before you recommend someone for eligibility for
9 life-altering hormones?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: Prior to making a
12 recommendation of hormone initiation I'm doing my own
13 assessment and ensuring that those standards are met.

14 BY ATTORNEY BARHAM:

15 Q. So beyond your own assessments do you have any
16 policies that guide that process?

17 A. Our clinic has its own policies dependent upon
18 clinical practice or whether or not patients are
19 enrolled in a particular trial, but it is the standard
20 of care as laid out by both Endocrine Society and WPATH
21 that adolescent patients have a psychological
22 assessment. There's a lot of latitude for what that
23 actually means.

24 Q. And on page three of this document, Exhibit 29,

1 the bottom of the first paragraph the authors write as a
2 result we may be harming some of the young people we
3 strive to support, people who may not be prepared for
4 the gender transitions they are being rushed into.

5 Do you share the concern of these authors?

6 A. I don't have numbers on my end. Which --- where
7 is it?

8 Q. (Indicating).

9 A. Got it. Can you repeat the question? Sorry.

10 Q. The authors express concern that we may be ---
11 quote, we may be harming some of the young people we
12 strive to support, people who may not be prepared for
13 the gender transitions they are being rushed into.

14 Do you share the author's concern?

15 A. I do not. These are tested hypotheses that can
16 be researched, and this is not what this is.

17 Q. You said you have no concern that people are
18 being rushed into gender transitions?

19 A. This is a supposition by these two authors that
20 people are being rushed into gender transition. I'm not
21 sure what that means, and that has not been the clinical
22 experience that I've had nor what the guidelines
23 recommend.

24 Q. So you were not aware of people being rushed

1 into transitions that they are not ready for?

2 A. That has not been my experience, no.

3 Q. On page four towards the bottom of the page, the
4 authors reference a recent study of 100 detransitioners,
5 38 percent of whom reported that they believe their
6 original dysphoria had been caused by something specific
7 such as trauma, abuse or mental health condition.
8 Fifty-five (55) percent of whom said they did not
9 receive adequate evaluation from a Dr. Or mental health
10 professional before starting transition.

11 Are you aware of that study that authors
12 reference here?

13 ATTORNEY BLOCK: Object to form.

14 THE WITNESS: I am --- I'm assuming
15 because I think they have a footnote in here somewhere,
16 but it is not in this particular article, but they are
17 receiving to the recent 2021 Littman study
18 detransitioners.

19 BY ATTORNEY BARHAM:

20 Q. Do you share the concern that some have been
21 misdiagnosed as transgender when their gender dysphoria
22 was, in fact, not innate, but cause by something
23 specific, such as trauma, abuse or mental health
24 condition?

1 A. I really don't mean to parse this, but I don't
2 know what Dr. Edwards-Leeper or Dr. Anderson's concerns
3 are, but the evidence that we have from the literature
4 and from our clinical experience is that this is not a
5 broad experience of most children.

6 Q. And what literature, are you referencing when
7 you say we referenced the literature?

8 A. I'm referencing the literature that I cited in
9 my report.

10 Q. And which specific portions of your report are
11 you referencing?

12 A. Let me just take a moment. What I'm referencing
13 is the longitudinal studies in particular that have
14 followed these kids over time.

15 Q. And which ones would those be in your report?

16 A. Really anything from the Dutch clinic is going
17 to have a longitudinal focus to them, but I think what's
18 more important is that in all of these studies, which
19 include some of the Dutch studies both in childhood and
20 adults that have looked at regret rates or detransition
21 have shown that this is a very infrequent occurrence,
22 and there has been nothing I've read within the
23 scientific literature that in, any way, tries to
24 operationalize this idea of children being forced into

1 or pressured into transition.

2 Q. What steps do you take to ensure that gender
3 dysphoria, the child's --- the child's or teen's gender
4 dysphoria was not caused by something specific such as
5 trauma, abuse or mental health condition before
6 recommending someone for puberty blocking or cross sex
7 hormones?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: I perform a thorough
10 evaluation.

11 BY ATTORNEY BARHAM:

12 Q. Anything beyond the thorough evaluation?

13 A. A very thorough evaluation. It involves
14 multiple steps as I described earlier.

15 Q. So this comprehensive --- the authors actually
16 talk about a comprehensive assessment on page three of
17 their article. And they indicate that comprehensive
18 assessment and gender exploratory therapy helps ---
19 quote, helps a young person peel back the layers of
20 their developing adolescent identity and examines
21 factors that contribute to their dysphoria. And those
22 include --- so what steps did you take to identify the
23 factors that may contribute to a child's or teen's sense
24 of dysphoria?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: It is a thorough assessment
3 and there are multiple factors within that assessment
4 that speak to those concerns specifically.

5 BY ATTORNEY BARHAM:

6 Q. And what are those multiple factors?

7 A. Understanding developmental history, getting
8 multiple performance, doing the diagnostic assessment of
9 any co-occurring mental health conditions and ensuring
10 that those are adequately explored and understood.

11 Q. What factors in a transgender identity do you
12 identify as most often contributing to gender dysphoria?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: I think it's complicated to
15 answer that in a short way, because not every child who
16 identifies as transgender would meet diagnostic criteria
17 for gender dysphoria. And specifically, if we agreed
18 with the premise that the gender dysphoria is being
19 caused by trauma that's specifically a rule out of the
20 diagnosis of gender dysphoria. So that is part of what
21 we're doing in an assessment is to understand the role
22 of other potential factors in helping a kid explore and
23 understand their identity.

24 BY ATTORNEY BARHAM:

1 Q. Then allow me to clarify the question. What
2 factors other than an innate transgender identity do you
3 identify as most often contributing to a child's
4 transgender identification?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: The children that I have
7 treated over my years of doing this work that describe a
8 gender identity that is inconsistent who don't
9 ultimately meet the criteria for gender dysphoria are
10 often children who have been subjected to multiple types
11 of trauma. That would be one of the factors.

12 BY ATTORNEY BARHAM:

13 Q. What other ones would you identify?

14 A. The other factors are around parental conflicts.
15 That's probably the other large cohort of kids when
16 exploration is the full come around which parents,
17 particularly divorcing parents, are acting in conflict.

18 Q. So by that you mean, for example one parent
19 supporting an affirmation approach and the other raising
20 concerns about proceeding in that direction?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: That's not an infrequent
23 occurrence and this is a very rare outcome to that, but
24 in that cohort of patients who desist, I would say in

1 their identities that is a shared characteristic of some
2 of the patients that I have seen.

3 BY ATTORNEY BARHAM:

4 Q. So you have not only two factors that could
5 contribute to a child's transgender identification,
6 other than ---?

7 A. Can I stop you, sir? I'm not identifying that
8 as a cause or a causal factor in a core gender identity.
9 It is the understanding and expression of that identity
10 that often changes.

11 Q. Okay.

12 And that is why I was trying to talk about
13 transgender identification more broadly. But you've
14 identified two factors that contribute to that not
15 necessarily causal but contribute. Are there any others
16 that you have identified as most often contributing
17 as ---?

18 A. Not that I have seen.

19 Q. The authors on page three express a concern
20 about other influences that patients can be subjected
21 to, so as in these assessments patients reflect on the
22 duration of the dysphoria they feel they continue a
23 gender --- the intersection of sexual orientation, et
24 cetera, social media, internet and peer influences.

1 Do you share concerns that teens maybe misled by
2 TikTok or other social media to self diagnose as
3 transgender when, in fact, other factors have driven
4 their gender dysphoria or their transgender
5 identification?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: To clarify transgender
8 isn't a diagnosis, so I'm not concerned about that
9 specifically. And I think that's the study of all
10 phenomenon, whether or not this is occurring, but again,
11 as a part of a comprehensive gender assessment, we are
12 looking at multiple factors beyond a child's
13 self-report.

14 BY ATTORNEY BARHAM:

15 Q. So do you share concerns that teens may be
16 misled by social media to self declare as transgender
17 when, in fact, other factors have driven their gender
18 dysphoria?

19 ATTORNEY BLOCK: Objection.

20 THE WITNESS: I would not characterize it
21 in that way.

22 BY ATTORNEY BARHAM:

23 Q. How would you characterize it?

24 A. I would characterize it by taking exploration of

1 an identity via TikTok for what it is, as a normal
2 process of adolescent development and having a child who
3 self identifies as transgender as a result of seeing a
4 video on TikTok is not going to be the child who meets
5 the typical phenomenology that we would see with gender
6 dysphoria. That is part of the assessment that we are
7 evaluating.

8 Q. Okay.

9 So then in general, you don't agree with the
10 concerns that the authors raise regarding the influence
11 of social media, internet and peer influences.

12 Correct?

13 A. I would say it's a matter of degree. I don't
14 think social media has been a particularly healthy thing
15 for kids in general, and understanding how it impacts
16 kids is something that we all need to be learning more
17 about.

18 Q. In the last paragraph on page three, the authors
19 talk about how the WPATH recommends collaborative
20 approach that involves parents and take into account the
21 complexities of adolescents.

22 Do you see that?

23 A. Yes.

24 Q. Do you understand the WPATH standards of care

1 for adolescents to call for a collaborative approach
2 that involves both parents whenever possible?

3 A. There is not a specific call out within the
4 standards of care for my recollection that say both
5 parents need be involved, but that's certainly implied
6 and is the general practice to include all parents or
7 all family members who are involved in the child's life
8 whomever is going to need to be in the room in order to
9 both get a clear understanding of what's going on as
10 well as make sure the child gets the adequate support to
11 be able to thrive.

12 Q. So is it your understanding that the WPATH
13 standards of care would allow treatment to proceed based
14 on the consent of one parent?

15 A. As we talked about earlier, these are guidelines
16 and not mandates. In practice within the United States
17 almost all consent processes for puberty suppression and
18 hormones go through a two parent consent process
19 whenever possible, even though that is not a requirement
20 of the law.

21 Q. What I'm trying to get to is what is the
22 requirements of the guidelines, recognizing that the
23 guidelines are not mandatory, but do the guidelines
24 allow for treatment based on the consent of one parent?

1 A. I think one of the limitations of an
2 international document is that there is not going to be
3 that level of specificity because consent laws are going
4 to be different from state to state, not to mention
5 country to country.

6 Q. Okay.

7 On page two --- I'm sorry, on page three ---
8 let me clarify again. I'm sorry I confused myself. On
9 page two the authors write that after exploring who she
10 was --- after a year of exploring who she was, Patricia
11 no longer felt she was a boy, she decided to stop
12 binding her breasts and wearing boys clothes.

13 What proportion of those who present at your
14 clinic change their minds and decided to remain with or
15 return to the gender identity of their natal sex before
16 undergoing any hormonal treatments?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: I'm one practitioner in my
19 clinic, so I don't have the data on everybody. And I
20 think a lot of that is going to depend upon the
21 population that you are seeing.

22 BY ATTORNEY BARHAM:

23 Q. What proportion of your patients then changed
24 their mind and decide to remain or return to the gender

1 identity of their natal sex before undergoing any
2 hormonal treatments?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: I would say a minority of
5 patients.

6 BY ATTORNEY BARHAM:

7 Q. Do you have a range?

8 A. I don't. I think when you were asking those
9 questions at the beginning about my 500 transgender
10 patients in that cohort, and I think 75 percent pursued
11 some things, but being that 25 percent that didn't.
12 Somewhere in there.

13 Q. On page five of this document, the last page the
14 authors report a rising a number of detransitioners that
15 clinicians report seeing. Are you aware of this rising
16 number of detransitioners?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: I'm aware that these two
19 authors are raising that it's a possibility. It is not
20 something that I've seen published in the literature.

21 BY ATTORNEY BARHAM:

22 Q. Have you seen a rising number of detransitioners
23 at your clinic?

24 A. I think the question is whether or not the

1 percentage is changing and that's not an answer we know.
2 I think by definition the more people you see the more
3 folks --- the detransition you're going to see. And the
4 difference of children who had access to gender care now
5 compared to a decade ago is just orders of magnitude
6 different. But I don't know or there has not been any
7 evidence that I've seen that the percentage of kids who
8 detransition is any different now than it was a decade
9 ago.

10 Q. A few paragraphs above what we were just looking
11 at, it says only a quarter of these individuals told
12 their doctors they had reversed their transitions making
13 this population especially hard to track. Would you
14 agree that this population is difficult to track?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: Again, this is not a study
17 and so it's hard to kind of make a pronouncement about a
18 population without a defined understanding of what that
19 population actually is. Our folks who don't talk to
20 their medical professionals about dissatisfaction in
21 their care, a difficult population to treat, I think,
22 probably by definition that is true.

23 BY ATTORNEY BARHAM:

24 Q. And to be clear, I wasn't asking if they're

1 difficult to treat, I was just asking would you agree
2 they're difficult to track?

3 A. I think by definition, yes, if they are not
4 reaching out to their providers or dropping out of
5 studies, yes.

6 Q. The next to last paragraph of this article
7 begins by saying the pressure by activists, medical and
8 mental health providers along with a national LGBT
9 organizations to silence the voices of detransitioners
10 and sabotage the discussion around what is occurring in
11 the field is unconscionable. Do you agree that it is
12 concerning that certain organizations are seeking to
13 silence the voice of detransitioners?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: It is not my experience
16 that organizations are seeking to silence the voices of
17 folks who identify as detransitioners, no.

18 BY ATTORNEY BARHAM:

19 Q. If they were would you agree that that is
20 unconscionable?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: My job as a psychiatrist
23 and a child psychiatrist in particular is to understand
24 the kid who is sitting in front of me in that very

1 moment. I want to understand how to best meet their
2 needs. So anything that is going to interfere with me
3 being able to understand that is going to be a problem
4 for me.

5 ATTORNEY BARHAM: I'm going to show you
6 what we will mark as Exhibit-30. This is also Tab 30.

7 ---

8 (Whereupon, Exhibit-30, Interview by Lisa
9 Selin Davis, was marked for
10 identification.)

11 ---

12 BY ATTORNEY BARHAM:

13 Q. This is an interview written up by Lisa Selin
14 Davis of Quillette entitled Trans Pioneer Explains her
15 Resignation from the U.S. Professional Association for
16 Transgender Health, published at the beginning of 2022.
17 Are you familiar with this article?

18 A. I am not.

19 Q. I'm going to direct your attention to
20 page three. This is an interview with Dr. Anderson, the
21 same individual who is a co-author of the Washington
22 Post article we were just discussing.

23 Correct?

24 A. That is correct.

1 Q. On page three Dr. Anderson states, the data are
2 very clear that adolescent girls are coming to gender
3 clinics in greater proportion than adolescent boys and
4 this is a change in the last couple of years and it's an
5 open question, what do we make of that. We really don't
6 know what's going on and we should be concerned about
7 it. Does her experience match your experience?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: I think it's consistent in
10 the literature that we've seen more assigned females at
11 birth presenting for care than in the past.

12 BY ATTORNEY BARHAM:

13 Q. And have you seen this change in balance since
14 approximately 2015?

15 A. I don't know if I would say --- I could point to
16 one specific year, but with each year it seems like
17 that's --- I think probably that's when the data came
18 out that that demonstrated it.

19 Q. When do you recall beginning to see this trend
20 develop?

21 A. I think one of the challenges is that the scope
22 of the literature is limited to a few very specific
23 subsets of where clinical care is practiced, and so we
24 have to just be careful not to completely generalize.

1 So in these specific clinics what we have seen is a
2 preponderance and an increase of assigned females at
3 birth. I can't speak to this being a national
4 phenomenon, but the literature probably certainly all
5 points in that direction. I think personally for me I
6 just started to see more assigned females at birth
7 presenting in adolescence I think in the mid 2010s is
8 not unreasonable.

9 Q. Is there any test in scientific understanding as
10 to why this trend in the literature is developing?

11 A. There is not.

12 Q. Do you agree that this is something that
13 practitioners should be very concerned about before
14 agreeing to administer sterilizing cross sex hormones to
15 teen girls?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: The thing that's important
18 is what are the specific factors of the child in the
19 family that is sitting in front of you and how to ensure
20 that that child has gotten appropriate care and that
21 we're making a recommendation based upon the best
22 interest of that individual child that is irrespective
23 of population-based changes that are happening.

24 BY ATTORNEY BARHAM:

1 Q. Don't you need to assess though whether the
2 individual in front of you is exemplar of that national
3 --- of that trend in the literature?

4 A. That's where --- that's where an assessment
5 comes in.

6 Q. So you would agree then that practitioners
7 should be concerned about this trend before deciding to
8 administer hormones.

9 Correct?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: What I'm stating is that
12 the guidelines for what's involved in assessment have
13 been relatively clear and that we want to make the
14 decisions based upon what's in the best interest and
15 understanding of the patient and family that we are
16 seeing. We should always be concerned. We should
17 always be building up our understanding of the field, as
18 well as some of the epidemiology of the field. But that
19 doesn't change the individual experiences of the patient
20 and the family that we're meeting with.

21 BY ATTORNEY BARHAM:

22 Q. Okay.

23 At the bottom of page four Dr. Anderson says
24 that she is, quote, worried that there is a new group of

1 adolescents who have preexisting mental health problems
2 and are looking for an explanation about who they are.
3 And there's a bit of I would say fantasy about seeking
4 to form an identity that may then explain their
5 distress. You would agree that the adolescent years can
6 be distressing for many teens, whether they are
7 transgender or not.

8 Correct?

9 ATTORNEY BLOCK: Objection to form.

10 THE WITNESS: I would wholly agree with
11 that, yes.

12 BY ATTORNEY BARHAM:

13 Q. Do you share the concern that some teens who
14 present at clinics are indulging in a fantasy about what
15 a transgender identity will do for them and their
16 distress?

17 A. I would not put it in that way, no.

18 Q. As part of your assessment do you have to --- as
19 part of your thorough assessment do you have to assess
20 whether the teen is incorrectly assessing what a
21 transgender identity would do for them and their
22 distress?

23 A. A part of any formed --- informed consent
24 process is assessing the understanding of the child and

1 the family's understanding of the risks, benefits and
2 alternatives of that specific intervention. That would
3 include an unrealistic belief about what the potential
4 benefits may be.

5 Q. All right.

6 I want to go to page five of this document.
7 Dr. Anderson indicates earlier today I talked to some
8 parents who brought their child to a health
9 professional. The child is seen three times by a
10 therapist and then recommended for hormones. The
11 therapist never talked to the parents. Do you share her
12 concern that three sessions with a mental health
13 providers is far less than required before a competent
14 diagnosis of a durable transgender identity can be made?

15 ATTORNEY BLOCK: Objection to the form.

16 THE WITNESS: I would not. The objection
17 as I read it in this article that you've put in front of
18 me with the interview with Dr. Anderson, her concern
19 seems to be more about not having spoken to the parents
20 prior to the recommendation. And I can't take her word
21 for it that this was true. We hear a lot of things from
22 parents who express frustration with care that is
23 ultimately found not to be accurate.

24 BY ATTORNEY BARHAM:

1 Q. Would you share the concern that prescribing
2 hormones if one parent is strongly opposed to it is
3 creating a likelihood of family conflict that is going
4 to likely be destabilizing and harmful to the child?

5 ATTORNEY BLOCK: Objection to the form.
6 Are you referencing something in the article or is this
7 your own question?

8 ATTORNEY BARHAM: I am referencing
9 page six, where Dr. Anderson says you don't want to rush
10 ahead with a kid, giving them encouragement that they're
11 going to get hormones until we bring their parents
12 along. Battling the parents is a no win proposition.

13 BY ATTORNEY BARHAM:

14 Q. So just to be clear about the question do you
15 share the concern that prescribing hormones if one
16 parent is strongly opposed is likely creating the
17 likelihood of family conflict that may be separately
18 destabilizing and harmful to the child?

19 ATTORNEY BLOCK: Objection to the form
20 and foundation.

21 THE WITNESS: What I hear Dr. Anderson's
22 concern from this is that battling with parents is a
23 no-win proposition. I think that's different from
24 recommending a treatment that not all parents agree to.

1 I think it's about the work of psychotherapy, which
2 involves understanding and hearing parents' experiences
3 and objections.

4 BY ATTORNEY BARHAM:

5 Q. Do you think that prescribing hormones if one
6 parent is strongly opposed is likely creating family
7 conflict that may be separately destabilizing and
8 harmful to the child?

9 A. I can't answer that question without a specific
10 family scenario in front of me. I have seen the
11 opposite be the case where the conflict is the creation
12 of the lack of consensus as opposed to the other way
13 around. And I've seen kids in my experience treating
14 kids who had parents who have opted out of any
15 decisional capacity and the kid's medical care but
16 nevertheless do much better when given access to this
17 care.

18 Q. But it is also possible that prescribing
19 hormones over the objection of one parent can create
20 conflict within the family.

21 Correct?

22 ATTORNEY BLOCK: Objection to the form.

23 THE WITNESS: Understanding the impact of
24 any intervention is a part of that consent process.

1 BY ATTORNEY BARHAM:

2 Q. I'm just asking if that's a possible outcome?

3 A. Yes.

4 Q. All right.

5 Is it your opinion that it's unreasonable to
6 exclude from female teams biological males, and by that
7 I mean people with XY chromosomes, who have gained a
8 physiological advantage as a result of undergoing male
9 puberty?

10 A. This is outside of the scope of what I was
11 providing my testimony on.

12 Q. Well, in paragraph 52 of your report you say no
13 reasonable mental health professional could think the
14 act in question is anything but harmful to the mental
15 health of transgender youth and that preventing
16 transgender youth from participating in the same
17 activities as their peers undermines their ability to
18 socially transition and prevents transgender youth from
19 accessing important educational and social benefits.

20 So I'm asking you is it your opinion that it's
21 unreasonable to exclude from female teams biological
22 males who have gained a physiological advantage as a
23 result of undergoing male puberty?

24 ATTORNEY BLOCK: Objection to form and

1 scope.

2 THE WITNESS: Again, I can testify to the
3 mental health aspects of exclusion. I can't testify to
4 the endocrinologic changes of the physiologic changes in
5 sports specifically.

6 BY ATTORNEY BARHAM:

7 Q. I'm not asking you to testify to the
8 endocrinology aspects of this. I'm just asking is it
9 your opinion that if we assume that an individual has
10 gained physiological advantage as a result of undergoing
11 male puberty that it is still unfair to --- or
12 unreasonable to exclude them from competing on a women's
13 team?

14 ATTORNEY BLOCK: Objection to form and
15 scope.

16 THE WITNESS: That is not an assumption I
17 feel comfortable making.

18 BY ATTORNEY BARHAM:

19 Q. Well, if you say that it is no reasonable mental
20 health professional can say that this Act is anything
21 but harmful to the mental health of transgender youth
22 that doesn't depend upon whether the child has undergone
23 male puberty or not.

24 Is that correct?

1 A. That is correct.

2 Q. So even if the child --- even if the individual
3 has undergone male puberty you're saying that no
4 reasonable mental health professional could think that
5 the Act is anything but harmful, barring them from
6 competing on the women's team is anything but harmful.

7 Is that correct?

8 A. I would say exclusion and isolation from access
9 to same aged peer activities is likely to be harmful
10 from a mental health perspective.

11 Q. To what extent can puberty blockers started
12 late, such as age 14, unring the bell by reversing
13 physical changes in male puberty?

14 ATTORNEY BLOCK: Sorry, I can't hear the
15 questions.

16 BY ATTORNEY BARHAM:

17 Q. To what extent do puberty blockers started late,
18 for example age 14, unring the bell by reversing the
19 physical changes of male puberty?

20 ATTORNEY BLOCK: Objection to form and
21 scope.

22 THE WITNESS: It is a complicated
23 question that is best left to an endocrinologist to
24 answer.

1 BY ATTORNEY BARHAM:

2 Q. Can puberty blockers reverse the physical
3 changes of male puberty to the genitals?

4 ATTORNEY BLOCK: Objection to form and
5 scope?

6 THE WITNESS: It's the same answer. I
7 would defer to an endocrinologist on that response.

8 BY ATTORNEY BARHAM:

9 Q. Can puberty blockers reverse the physical
10 changes to the hair?

11 ATTORNEY BLOCK: Same objections.

12 THE WITNESS: Again, I would defer to an
13 endocrinologist.

14 BY ATTORNEY BARHAM:

15 Q. Can they reverse the physical changes to the
16 voice or the muscles?

17 ATTORNEY BLOCK: Same objections.

18 THE WITNESS: Same answer.

19 BY ATTORNEY BARHAM:

20 Q. Can they reverse the effect --- the physical
21 changes of male puberty to the heart or lung size?

22 ATTORNEY BLOCK: Same objection.

23 THE WITNESS: Same answer.

24 BY ATTORNEY BARNHAM:

1 Q. Isn't it true that puberty blockers just stop
2 further typical male development?

3 ATTORNEY BLOCK: Same objections.

4 THE WITNESS: I would --- I would give
5 two responses. One, I would want an endocrinologist to
6 weigh in on the specifics, but clearly puberty blockers
7 are also prescribed to folks assigned females at birth
8 as well. There's more than just impacts on testosterone
9 as a result of these medications.

10 BY ATTORNEY BARHAM:

11 Q. I understand, but you make recommendations for
12 whether people are eligible to receive puberty blocking
13 hormones.

14 Is that correct?

15 A. That is correct.

16 Q. So you have to have some understanding of the
17 effects of these medications.

18 Is that correct?

19 A. That is correct.

20 Q. So isn't it true that puberty blockers
21 administered to natal males should stop further typical
22 male development?

23 ATTORNEY BLOCK: Objection to form and
24 scope.

1 THE WITNESS: I'd have the same answer,
2 and they do more than that.

3 BY ATTORNEY BARNHAM:

4 Q. What else do they do?

5 A. Again, I would defer to the endocrinologist for
6 the specific pathophysiology of how GnRH analogs affect
7 a complicated physiology of the body.

8 Q. But what is your understanding of how they
9 affect because you said they also do other things?

10 ATTORNEY BLOCK: Objection to form and
11 scope.

12 THE WITNESS: I think I answered it. In
13 the GnRH analogs are given an anatomic manner compared
14 to the pulsatile way in which GnRH is released during
15 the puberty, which is what causes the suppression of
16 other hormones more than just testosterone and estrogen.

17 BY ATTORNEY BARNHAM:

18 Q. If puberty blocking hormones are administered to
19 a natal male, do they cause that individual to undergo
20 typically female pubertal development?

21 ATTORNEY BLOCK: Objection to form and
22 scope.

23 THE WITNESS: They do not.

24 BY ATTORNEY BARHAM:

1 Q. So they just stop further male development.

2 Correct?

3 ATTORNEY BLOCK: Same objections.

4 THE WITNESS: As kind of a Gestalt pithy
5 response, yes, they cause puberty for assigned females
6 at birth and assigned males at birth who are given these
7 medications.

8 BY ATTORNEY BARNHAM:

9 Q. When does puberty typically begin in biological
10 males?

11 ATTORNEY BLOCK: Same objections.

12 THE WITNESS: Those are very known data
13 that an endocrinologist could tell you.

14 BY ATTORNEY BARHAM:

15 Q. I'm sure, though, that as a psychiatrist you
16 have a general understanding of what ages puberty
17 typically begins in biological males?

18 ATTORNEY BLOCK: Same objections.

19 THE WITNESS: I do, however, I am
20 assessing individuals who come through my office. And
21 regardless of what the population says about when
22 puberty is typical, it's going to depend upon who that
23 individual child is and when they develop puberty.

24 BY ATTORNEY BARHAM:

1 Q. I understand, but my question isn't about an
2 individual. My question is when does it typically begin
3 in biological males.

4 ATTORNEY BLOCK: Same objections.

5 THE WITNESS: Again, this is a very
6 knowable fact-based answer in a population level. It's
7 not information I have in front of me.

8 BY ATTORNEY BARHAM:

9 Q. So you have no --- is it your testimony that you
10 have no information as to when puberty typically begins
11 in biological females?

12 ATTORNEY BLOCK: Can I just give a
13 standing objection to questions asking the witness about
14 the effects --- the endocrinology effects of blockers
15 and hormones, so I don't have to make an objection each
16 time?

17 ATTORNEY BARHAM: Yes.

18 THE WITNESS: My testimony is I don't
19 want to give an imprecise answer for a question that
20 there is a specific answer to.

21 BY ATTORNEY BARHAM:

22 Q. What is your understanding, as you sit here
23 today, as to when puberty typically begins in males?

24 A. The range for typical puberty in males tends to

1 be around the 12ish mark. But there is a broad
2 variability. And again, there is an answer that exists
3 for this question that I don't have in front of me.

4 Q. Are you familiar with Tanner stages of puberty?

5 A. I am.

6 Q. What are the different Tanner stages of puberty?

7 A. Tanner stages one through five are the different
8 Tanner stages.

9 Q. So what is Tanner stage one in biological males?

10 A. It depends upon if we're talking about genitalia
11 or chest development, but it's no pubertal changes,
12 so ---.

13 Q. And what is two?

14 A. Two is at the initial stages of pubertal changes
15 that you start to see. The specifics of the Tanner
16 staging is something that you need to be trained on. I
17 would not claim myself as an expert in being able to
18 accurately access the Tanner stage of a child.

19 Q. Do you know when --- at what ages Tanner Stage 2
20 typically initiates in biological males?

21 A. Again, it's going to be an individualized
22 experience and that's why we do assessments.

23 Q. Do you have a range, an age range as to when it
24 typically begins?

1 A. When we talk about the onset of puberty, we're
2 talking about Tanner stage two typically.

3 Q. And at what age do those typically arise?

4 A. For assigned males at birth or assigned females?

5 Q. For biological males.

6 ATTORNEY BLOCK: Objection to
7 terminology.

8 THE WITNESS: So for folks assigned male
9 at birth, again, we're going to see it in that 12-ish
10 range.

11 BY ATTORNEY BARHAM:

12 Q. And Tanner Stage 3, what is that?

13 A. Further development. There's tables and charts
14 you would have to look at. I'm not going to be able to
15 use language to describe it in an accurate way.

16 Q. And when --- approximately when, what age range
17 does Tanner Stage 3 begin in biological males?

18 A. That's not an answer that I can give you.

19 Q. And what is Tanner Stage 4?

20 A. The same answer is further progression of
21 pubertal changes.

22 Q. And do you know what age range that typically
23 begins in biological males?

24 A. Same answer as before. That's not an answer I

1 have here.

2 Q. And would the same answers hold true for Tanner
3 Stage 5? Is that a yes?

4 A. That's a yes. I forgot that nodding ---.

5 Q. Yes. You've been pretty good today. I've been
6 impressed.

7 Doesn't the position that allowing biological
8 males to play on a girls team if they blocked puberty
9 before it begins create pressure for parents and
10 children to make puberty blocking decision at a young
11 age?

12 ATTORNEY BLOCK: Objection to form.

13 BY ATTORNEY BARHAM:

14 Q. Sort of put them in a now or never situation?

15 A. Of those 500 patients that I have seen, that has
16 never come up as a concern.

17 Q. The athletic issue has never come up as a
18 concern?

19 A. It has not.

20 Q. Do you think it would --- as a practitioner in
21 the field do you think it would even be ethical for the
22 State of West Virginia to structure its law in a way
23 that puts now or never pressure on parents and children
24 who are dealing with gender dysphoria to decide at an

1 early age whether to stop the natural development of
2 puberty?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: As a child psychiatrist in
5 this field we're doing individual-based assessments with
6 the children and families that are in front of us. And
7 what that means in the context of this question is that
8 we are assessing all of their different activities,
9 interests and working with all the systems that we can
10 to ensure a safe and appropriate set of decisions that
11 are going to lead to the best outcomes for this
12 individual child and not a medical emphasis that is
13 outside of the scope that I can answer.

14 BY ATTORNEY BARHAM:

15 Q. But you're familiar with the ethical standards
16 of your field.

17 Is that correct?

18 A. I am, yes.

19 Q. Under those ethical standards would it be
20 ethical for the State to structure its law in a way that
21 puts this kind of now or never pressure on parents and
22 children?

23 ATTORNEY BLOCK: Objection to form. Also
24 the witness is in shadow. I can't really see him for

1 the camera.

2 THE WITNESS: Is that better?

3 ATTORNEY BLOCK: Yes.

4 THE WITNESS: Can you repeat the
5 question? I'm sorry.

6 BY ATTORNEY BARHAM:

7 Q. As someone familiar with the ethical standards
8 of psychiatry, do you think it would be ethical for the
9 State of West Virginia to structure its law in a way
10 that puts now or never pressure on parents and children
11 who are dealing with gender dysphoria to decide at an
12 early age whether to stop the natural development of
13 puberty?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: I mean that's a question
16 that has a testable hypothesis. Does X intervention
17 lead to this kind of pressure? That's not a study that
18 I've ever seen nor has it been my clinical experience
19 that it's been the case.

20 BY ATTORNEY BARHAM:

21 Q. Would it be ethical to put that kind of pressure
22 on someone under the ethical standards of the field of
23 psychiatry?

24 ATTORNEY BLOCK: Objection to form and

1 foundation?

2 THE WITNESS: It is a very theoretical
3 question that really doesn't enter into it when we are
4 one on one with these kids and their families.

5 BY ATTORNEY BARHAM:

6 Q. I'm not asking about one on one interactions
7 with kids and families. I'm asking in general in theory
8 is it ethical to put that kind of pressure on someone?

9 ATTORNEY BLOCK: Objection to form and
10 foundation.

11 THE WITNESS: I'm sorry I can't give a
12 better answer, but ensuring that a child is making a
13 decision without coercion is a part of the informed
14 consent process.

15 BY ATTORNEY BARHAM:

16 Q. Is it your opinion that it is unreasonable to
17 exclude from female teams biological males who begin
18 undergoing male puberty but are now on puberty blockers?

19 ATTORNEY BLOCK: Objection to form and
20 scope.

21 THE WITNESS: Can you repeat the
22 question?

23 BY ATTORNEY BARHAM:

24 Q. Is it your opinion that it is unreasonable to

1 exclude from female teams biological males who begin
2 undergoing male puberty but are now on puberty blockers?

3 A. Is it unethical is the question?

4 Q. Unreasonable.

5 A. Unreasonable. I would defer to kind of our
6 physiology and endocrinology experts and our medical
7 ethics experts in rendering an opinion on that
8 specifically.

9 Q. Is it your opinion that it is harmful to youth's
10 mental health to be excluded from female teams
11 biological males who begin undergoing male puberty but
12 are now on puberty blockers?

13 A. What I would say is that exclusion as well as
14 specific legal exclusion from activities of same-aged
15 peers is likely to be harmful for a kid's mental health.

16 Q. Now, the Act in question does not prevent a
17 biological male who has gender dysphoria from competing
18 on the boys team.

19 Is that correct?

20 ATTORNEY BLOCK: Objection to form and
21 scope.

22 THE WITNESS: I'd need to know specifics.
23 I don't know what you're referring to. I think lots of
24 people have different policies around how this actually

1 works.

2 BY ATTORNEY BARHAM:

3 Q. I'm asking your understanding of the statute
4 upon which you're opining.

5 A. Can you repeat the question, please?

6 Q. The Act in question does not prevent a
7 biological male who is experiencing gender dysphoria
8 from competing on the boys team.

9 Correct?

10 ATTORNEY BLOCK: Objection to form and
11 scope.

12 THE WITNESS: So one, I don't know what
13 biological male necessarily means.

14 BY ATTORNEY BARHAM:

15 Q. An individual with XY chromosomes, natal male?

16 A. So assigned male at birth can have a number of
17 reasons why they might not be able to play on the boys
18 team, including intensity of gender dysphoria.

19 Q. But the law does not prevent them from playing
20 on the boys team.

21 Correct?

22 A. From my read of the law it does not prevent them
23 from playing on the boys team. Again, from a mental
24 health perspective, their gender dysphoria may.

1 Q. So is it harmful to the mental health of a
2 biological male who is experiencing gender dysphoria to
3 be excluded from the women's team even if he is on
4 puberty blockers?

5 ATTORNEY BLOCK: Objection to form and
6 terminology.

7 THE WITNESS: Any potential exclusions
8 from a peer-appropriate activity has the potential to
9 have negative consequences on the mental health of that
10 girl. And again, that's going to be something that on
11 an individual basis we are assessing.

12 BY ATTORNEY BARHAM:

13 Q. And that would be irrespective of whether the
14 individual is on puberty blockers, begins to undergo
15 male puberty or not.

16 Correct?

17 A. An individual assessment is going to be
18 inherently tailored to wherever an individual is.

19 ATTORNEY BARHAM: Why don't we pause for
20 lunch?

21 ATTORNEY BLOCK: Let's go off the record.

22 VIDEOGRAPHER: Going off the record. The
23 current time reads 1:24 p.m.

24 OFF VIDEOTAPE

1 ---

2 (WHEREUPON, A SHORT BREAK WAS TAKEN.)

3 ---

4 ON VIDEOTAPE

5 VIDEOGRAPHER: Back on the record. The
6 current time reads 1:53 p.m.

7 BY ATTORNEY BROOKS:

8 Q. What does puberty suppression or puberty
9 blockers do?

10 ATTORNEY BLOCK: Objection to form and
11 scope.

12 THE WITNESS: I think I answered that
13 question before. So they suppress the endogenous
14 release of testosterone and estrogen as well as some
15 other hormones.

16 BY ATTORNEY BARHAM:

17 Q. How does puberty suppression differ from cross
18 sex hormones?

19 ATTORNEY BLOCK: Same objection.

20 THE WITNESS: Totally different
21 medication. One suppress hormones and the other is a
22 direct hormone itself.

23 BY ATTORNEY BARHAM:

24 Q. So cross sex hormones are given with the

1 intention of causing development typical to the other
2 sex.

3 Correct?

4 A. It depends upon the context in which hormones
5 are used. And again, I would defer for my endocrinology
6 colleagues on the specifics.

7 Q. So if cross sex hormones are given to a natal
8 male as part of treatment for gender dysphoria, what is
9 the intention?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: As I understand it, if an
12 assigned male at birth is given cross sex hormones that
13 is estrogen in order to provide the effects of estrogen
14 on the body.

15 BY ATTORNEY BARHAM:

16 Q. And the effects of estrogen on the body are what
17 natal females would naturally experience as a result of
18 puberty.

19 Correct

20 A. I mean, that is correct, yes.

21 Q. And so if a natal female is given cross sex
22 hormones, she's being given testosterone to create the
23 effects that natal males would naturally experience
24 through puberty.

1 Correct?

2 A. Typically speaking, an assigned female at birth
3 is going to be receiving testosterone and will have the
4 subsequent effects as a result of having testosterone in
5 the bloodstream.

6 Q. Maybe I was confused, a natal male who is given
7 cross sex hormones?

8 A. You were right.

9 Q. I was right, okay. At what Tanner stage do you
10 recommend that a patient begin puberty blocker hormones?

11 A. Again, that's going to depend upon an
12 individualized assessment with the family, but never
13 before Tanner Stage 2 of puberty.

14 Q. And in what age does Tanner Stage 2 begin again?

15 ATTORNEY BLOCK: Asked and answered.

16 THE WITNESS: I think I answered that
17 question. It really depends upon the person.

18 BY ATTORNEY BARHAM:

19 Q. And typically ---.

20 A. And for an assigned male at birth we're talking
21 12-ish, but again I would refer to my endocrinology
22 colleagues on the specific dates.

23 Q. And through what Tanner stage do you recommend
24 that a patient remain on puberty blockers?

1 A. That's not a question I can speak to. That's a
2 question for the physician or provider who's prescribing
3 that specific medication.

4 Q. So after you recommend that a patient receive
5 puberty blocking hormones, what is your continuing
6 involvement in the puberty blocking process?

7 A. My continuing involvement really depends upon
8 the individual child and family for the sake of a mental
9 health assessment. For the initiation of puberty
10 suppression it's an assessment for the initiation of
11 puberty suppression. The involvement thereafter is
12 really dependent upon what the individual needs of that
13 child are.

14 Q. Do you play any role in continuing to advise
15 whether the patient can continue to receive puberty
16 blocking hormones or come off of them?

17 A. It really depends upon the context. If the
18 child is seeking to come off of puberty suppression
19 because of a shift in their understanding of their
20 identity, certainly that's a conversation that I would
21 be involved in. If they are coming off of puberty
22 suppression because they have a sufficient amount of
23 testosterone or estrogen in their system that they are
24 no longer requiring that from a medical purpose, that's

1 not a discussion that I'm privy to.

2 Q. When you are discussing puberty blockers with
3 patients and their parents do you describe them as
4 placing a pause on puberty?

5 A. That's not specific language that I use.

6 Q. Do you describe them as being reversible?

7 A. Again, that's not a language that I use. I'm
8 much more specific in my discussions.

9 Q. So on the issue of whether puberty blocking
10 hormones are reversible, what do you tell parents and
11 patients?

12 A. I would say, by and large, most of the effects
13 of puberty suppression are reversible.

14 Q. And when you say by and large what effects are
15 you referencing?

16 A. What I'm referencing is that the literature is
17 still an open book and we are constantly seeking and
18 learning new information. We want to understand what
19 those potential new data tell us about the efficacy,
20 safety, et cetera, of these interventions.

21 Q. So when you say they are by and large the
22 effects are reversible, which effects are you
23 referencing are the by and large?

24 A. When I say by and large, it's really a caveat to

1 allow for the things that we don't yet know.

2 Q. So which effects are reversible?

3 A. Virtually all of the effects that we're aware of
4 are reversible.

5 Q. When you're discussing puberty blockers with
6 patients and their parents do you describe them as safe?

7 A. Safe isn't a binary concept in my world. There
8 is no such thing as anything that is completely safe or
9 unsafe. So we talk about gradations of risk with any
10 intervention.

11 Q. So for puberty blockers what are the --- what's
12 the gradation of risk?

13 A. It is individualized to the specific needs of
14 the child and the family.

15 Q. In general, what is your understanding of the
16 gradations of risk across the board?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: I don't have a better
19 answer for you because that's the whole process of doing
20 an informed consent process, is understanding what are
21 the specific risks and benefits and alternatives for
22 that individual child.

23 BY ATTORNEY BARHAM:

24 Q. Are you aware of the literature regarding any

1 testing of puberty blocking hormones and the gradations
2 of risks presented in those tests?

3 A. I'm not sure what you mean by tests.

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: I'm not sure what you mean
6 by testing.

7 BY ATTORNEY BARHAM:

8 Q. Don't medications undergo testing before they
9 can be used?

10 A. There's a wide variety of processes by which
11 medications are approved or not approved for certain
12 indications.

13 ATTORNEY BARHAM: Let's go to Tab 5. I
14 believe that's Exhibit-2.

15 LAW CLERK WILKINSON: Exhibit-2.

16 BY ATTORNEY BARHAM:

17 Q. It's the Endocrine Society Guidelines from 2017.

18 THE WITNESS: Yes.

19 BY ATTORNEY BARHAM:

20 Q. On page 3880 the Endocrine Society states we
21 suggest that clinicians begin pubertal hormone
22 suppression therapy --- pubertal hormone suppression
23 after girls and boys first exhibit physical changes of
24 puberty, Tanner stages G-2/B-2. Is that consistent with

1 your practice?

2 ATTORNEY BLOCK: Objection to form.

3 THE WITNESS: This is --- the document,
4 as I read it, is a set of guidelines for the practice of
5 care that should be individually applied to each child
6 and family. My practice takes these recommendations and
7 individually applies them to the specific risks,
8 benefits and alternatives for the child sitting in front
9 of me.

10 BY ATTORNEY BARHAM:

11 Q. On the prior page in number 1.4 the Endocrine
12 Society recommends against puberty blocking and gender
13 affirming hormone treatment in prepubertal children. Do
14 you approve the use of puberty blockers before puberty?

15 A. I do not.

16 Q. You didn't recommend or prescribe any puberty
17 blockers for BPJ.

18 Is that correct?

19 A. I have not.

20 Q. You did not evaluate BPJ before he started
21 taking puberty blockers.

22 Is that correct?

23 A. I have not evaluated her or seen her, these
24 materials.

1 Q. Is it your opinion that no responsible clinics
2 begin puberty blocking before puberty begins?

3 ATTORNEY BLOCK: Objection to form and
4 scope.

5 THE WITNESS: There's no indication to
6 start puberty blocking agents until Tanner Stage 2.

7 BY ATTORNEY BARHAM:

8 Q. Isn't it true that there have been no Phase I
9 clinical trials to test the safety of GnRH inhibitors
10 for this age group?

11 A. That is my understanding, but I would have to
12 specifically review the literature with that question in
13 mind. I'm not familiar --- completely familiar with the
14 phased nomenclature in this context.

15 Q. Isn't it true that there have been no Phase I
16 clinical trials to test the safety of GnRH inhibitors
17 for this duration?

18 A. Again I would need to find a definition of what
19 you are referring to by Phase I specifically.

20 Q. Isn't it true there have been no clinical trials
21 per FDA rules for this use of puberty blockers?

22 A. I don't know what is meant by per FDA rules.

23 Q. Food and Drug Administration rules?

24 A. Yeah. I'm not familiar with what their rules

1 are. There have been clinical trials of these
2 medications for this purpose.

3 Q. Which clinical trials are you referencing?

4 A. There are clinical trials through the Dutch
5 clinic. There is also an ongoing clinical trial here in
6 the U.S., a multi-phase study.

7 Q. That study is still ongoing.

8 Correct.

9 A. That is correct.

10 Q. So there are no completed clinical trials in the
11 United States under FDA rules.

12 Correct?

13 A. I am not ---.

14 ATTORNEY BLOCK: Objection to the form.

15 THE WITNESS: I can't say that I'm
16 familiar with all clinical trials that have ever
17 happened, so that's not a statement I can answer.

18 BY ATTORNEY BARHAM:

19 Q. You're not aware of any, though?

20 A. I don't know what is meant by Phase I and what
21 specifically is registered with the FDA for their
22 purposes versus the copious numbers of clinical trials
23 that have happened.

24 Q. Are you aware of any clinical trials in the

1 United States that have been completed regarding the
2 safety of using puberty blockers for gender dysphoria?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: Yeah, I'm not sure how I
5 can answer that because I'm not aware of all of the
6 trials that have occurred.

7 ATTORNEY BLOCK: Counsel, can we have a
8 discussion about the scope of this deposition? I'm
9 happy to have it off the record. I don't want it to
10 influence the witness at all, but this is a rebuttal
11 witness addressing specific issues and it seems that,
12 you know, there are a lot of questions that are just
13 really far outside the scope. So I'd love to have a
14 discussion.

15 ATTORNEY BARHAM: I'm happy to go off the
16 record.

17 VIDEOGRAPHER: Going off the record. The
18 current time reads 2:07 p.m.

19 OFF VIDEOTAPE

20 ---

21 (WHEREUPON, AN OFF RECORD DISCUSSION WAS HELD.)

22 ---

23 ON VIDEOTAPE

24 VIDEOGRAPHER: Back on the record. The

1 current time reads 2:17 p.m.

2 BY ATTORNEY BARHAM:

3 Q. We were looking at Tab 5, which is Exhibit-2,
4 page 3874. About three-quarters down the first column
5 the Endocrine Society indicates, quote, in the future we
6 need more rigorous evaluations of the effectiveness and
7 safety of endocrine and surgical protocols and
8 specifically highlight the need to include a careful
9 assessment of the effect of prolonged delay of puberty
10 in adolescence on bone health, gonadal function and the
11 brain.

12 Do you see that?

13 A. I see that, yes.

14 Q. Do you agree that more rigorous evaluations of
15 the safety of endocrine and surgical protocols are
16 needed?

17 A. I would agree that that's an important goal for
18 all treatments, yes.

19 Q. Do you agree that because, as the Endocrine
20 Society indicated here, that these evaluations are
21 needed in the future, that this --- that they have not
22 been done yet?

23 A. Well, this is published in 2017. There are
24 ongoing trials that are happening now, and some that

1 have had at least preliminary data presented at various
2 meetings that have looked at some of these.

3 Q. So the issue here is the prolong delay of
4 puberty. You would agree that it's quite different from
5 treating individuals with precocious puberty.

6 Correct?

7 ATTORNEY BLOCK: Objection to form and
8 scope.

9 THE WITNESS: As a non-endocrinologist I
10 wouldn't hazard an opinion on that.

11 BY ATTORNEY BARHAM:

12 Q. Do you treat individuals for precocious puberty?

13 A. I do not.

14 Q. Do you agree with the Endocrine Society that
15 there have not yet been a study of how the prolonged
16 delay of puberty affects bone health?

17 ATTORNEY BLOCK: Objection to form and
18 scope.

19 THE WITNESS: I don't know if I can
20 answer that in the most accurate way. I know I've seen
21 preliminary data presented at various meetings about
22 impacts on bone health, but I'm not as familiar with the
23 endocrine literature as I am with the mental health
24 literature.

1 BY ATTORNEY BARHAM:

2 Q. Do you agree that there has not yet been a study
3 on the prolonged effect of --- the prolonged delay of
4 puberty affecting gonadal function?

5 ATTORNEY BLOCK: Objection to form and
6 scope.

7 THE WITNESS: Same answer as to the last
8 one.

9 BY ATTORNEY BARNHAM:

10 Q. And that is the same as fertility?

11 Correct?

12 A. There has been more study fertility in those
13 populations.

14 Q. Do you agree there has not yet been a study on
15 how the prolonged delay of puberty affects the brain?

16 A. There are ongoing studies.

17 Q. None complete yet?

18 A. None that have published thus far that I'm aware
19 of again.

20 Q. And when you say there are ongoing studies of
21 bone health, none have published so far that you're
22 aware of.

23 Correct?

24 A. I know I have seen data published at various

1 national and international meetings, so I could not
2 answer that question accurately. I think things have
3 been published on bone health, but I'm not familiar with
4 --- I'm not as familiar with the endocrinologic
5 literature as I am the mental health literature.

6 Q. Are you aware of any studies that have been
7 completed regarding the prolonged delay of puberty
8 affecting the cognitive, emotional, social and sexual
9 development?

10 A. Can you repeat the question?

11 Q. Are you aware of any studies that have been
12 completed regarding the prolonged delay --- of how the
13 prolonged delay of puberty affects the cognitive,
14 emotional, social and sexual development?

15 A. There have been a number of studies including
16 studies that we have referenced here that have looked at
17 long-term psychosocial outcomes for these kids. So
18 certainly some of those items have been looked at quite
19 extensively. Some have not yet or have studies that are
20 ongoing.

21 Q. If the Endocrine Society is indicating that all
22 of this is needed research, why are you --- what do you
23 tell parents about the relative safety of puberty
24 blocking hormones?

1 A. What I would say this was published in 2017, and
2 so we would want to update since then about any
3 literature since then on these potential risks. What I
4 want to do is make sure that the endocrinologist or the
5 adolescent medicine specialist, whoever it is that is
6 prescribing the specific treatment knows how to have
7 those discussions based on the psychiatric needs of the
8 patients that I'm seeing.

9 Q. Let's turn to 3872 in this document. The
10 Endocrine Society indicates that the task force followed
11 the approach recommended by the grading of
12 recommendations and assessments, development and
13 evaluation group. The international group with
14 expertise in the development and implementation of
15 evidence based guidelines. Do you see that in the
16 second column?

17 A. Yes.

18 Q. And in this document they indicate that the use
19 of the phrase we recommend and the number one are strong
20 recommendations --- use the phrase we recommend ---
21 recommendations use the phrase of we suggest in number
22 two.

23 Is that correct?

24 A. Correct.

1 Q. So the recommendations regarding the use of
2 puberty blockers are based on low quality evidence.

3 Correct?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: What I can state is how
6 this particular working group within the Endocrine
7 Society characterized it using the assessment tool and
8 using this assessment tool that is how it was graded for
9 the sake of this set of guidelines.

10 BY ATTORNEY BARHAM:

11 Q. Were you aware of this when you drafted your
12 report?

13 A. Yes.

14 Q. Do you agree or disagree with this assessment of
15 the quality of the evidence?

16 A. Based upon how they did it, I would agree. In
17 the world of child psychiatry this is very common.
18 There is very little that we have in terms of very
19 mainstream standard of care treatments that has anything
20 other than poor quality of evidence based upon using
21 these standards.

22 ATTORNEY BARHAM: I'm going to hand you
23 what we will mark as Exhibit 31, and that will be
24 Tab 76?

1 THE WITNESS: Thanks.

2 LAW CLERK WILKINSON: You're welcome.

3 ---

4 (Whereupon, Exhibit 31, Label of Lupron,
5 was marked for identification.)

6 ---

7 BY ATTORNEY BARHAM:

8 Q. This is the label of Lupron, pharmaceutical
9 label for Lupron. Right at the top of page one, this
10 label indicates that Lupron is approved for puberty
11 blocking or delay for precocious puberty.

12 Correct?

13 A. That is correct.

14 Q. And precocious puberty is a hormonal imbalance.
15 Correct?

16 A. I think there's a precise terminology for
17 precocious puberty that involves more than just a
18 hormonal imbalance.

19 Q. But it's a malfunction of hormonal controls in
20 the brain?

21 ATTORNEY BLOCK: Objection to the form.

22 THE WITNESS: My understanding as a
23 non-endocrinologist is that's initiation of puberty much
24 earlier than anticipated or expected based upon the

1 history of the family.

2 BY ATTORNEY BARHAM:

3 Q. So Lupron is inspected and approved by the FDA
4 for safety and efficacy for precocious puberty not for
5 all other possible uses.

6 Correct?

7 A. Correct.

8 Q. And Lupron was tested only for delaying puberty
9 up until the normal age of puberty.

10 Correct?

11 ATTORNEY BLOCK: Objection to form.

12 THE WITNESS: I'm not familiar with the
13 literature that was used for gaining the FDA approval
14 for this indication.

15 BY ATTORNEY BARHAM:

16 Q. If you turn to section 14.1, 14.1 you'll see
17 that it says that this --- Lupron was tested for monthly
18 administration on 6 males and 49 females.

19 Is that correct?

20 A. That is correct.

21 Q. And on the next page you'll see it was tested
22 for three months administration on 8 males and 76
23 females.

24 Is that correct?

1 A. I do not see where it says that.

2 Q. 14.2?

3 A. Yes.

4 Q. Do you know why the test was weighted towards
5 girls?

6 ATTORNEY BLOCK: Objection to form and
7 scope and foundation.

8 THE WITNESS: It would be a mere
9 supposition on my end.

10 BY ATTORNEY BARHAM:

11 Q. Is it because precocious puberty is more common
12 in girls?

13 A. I would defer to an endocrinologist on this
14 epidemiology of that.

15 Q. But the goal of using Lupron in this context is
16 to help steer the body into healthy and normal
17 development.

18 Correct?

19 ATTORNEY BLOCK: Objection to form,
20 scope.

21 THE WITNESS: Generally speaking I would
22 agree with that.

23 BY ATTORNEY BARHAM:

24 Q. Prescribing Lupron or other GnRH for gender

1 dysphoria disrupts hormones and developments at an early
2 stage.

3 Correct?

4 ATTORNEY BLOCK: Objection to the form
5 and scope.

6 THE WITNESS: Again, as a mental health
7 professional, this would be outside of my area of
8 expertise to comment on that.

9 BY ATTORNEY BARHAM:

10 Q. Would you agree that normal pubertal development
11 includes bone growth, such as height?

12 ATTORNEY BLOCK: Objection to form and
13 scope.

14 THE WITNESS: Yes, I would.

15 BY ATTORNEY BARHAM:

16 Q. Would you agree that normal pubertal development
17 can include bone strengthening?

18 ATTORNEY BLOCK: Objection to form and
19 scope.

20 THE WITNESS: Specifics of that question
21 are really outside of my scope of understanding in the
22 practice that I have.

23 BY ATTORNEY BARHAM:

24 Q. But in general, you would agree that bones get

1 stronger during puberty, especially for men?

2 ATTORNEY BLOCK: Objection to form and
3 scope.

4 THE WITNESS: My understanding is that
5 the process of bone health is a quite dynamic, not
6 static nor binary process, so it's more complicated than
7 I feel that I can answer that question to.

8 BY ATTORNEY BARHAM:

9 Q. But do bones generally get stronger as puberty
10 progresses?

11 ATTORNEY BLOCK: Objection to form and
12 scope.

13 THE WITNESS: Again, I think it's a more
14 complicated answer than a yes or a no but I'm not ---.

15 BY ATTORNEY BARHAM:

16 Q. Would you agree that normal pubertal development
17 includes brain development?

18 A. Yes.

19 Q. Each of these things have stopped or decreased
20 by the administration of puberty blockers.

21 Correct?

22 A. I don't think we can say that it's been stopped
23 or decreased. There's not a term decreasing brain
24 development that has been studied or referred to in the

1 literature as I'm aware of it.

2 Q. Slower brain development?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: Slower isn't a word that
5 I've used, seen in the literature either.

6 ATTORNEY TRYON: Travis, can you speak up
7 just a little bit more, please?

8 ATTORNEY BARHAM: Certainly.

9 BY ATTORNEY BARHAM:

10 Q. Would you agree that normal pubertal development
11 also includes psychosocial development of an adult
12 identity as a sexual being contemporaneous with ones
13 peers?

14 A. I would say I would agree with that as an
15 adolescent developmental process, not necessarily as a
16 pubertal developmental process.

17 Q. What's the --- what's your distinction between
18 an adolescent pubertal development --- excuse me, an
19 adolescent developmental process and a pubertal
20 developmental process?

21 A. As an example, folks who have delayed puberty,
22 so 16-year olds who I have seen that have yet to undergo
23 all stages of puberty nevertheless develop a sense of
24 identity independent of the fact that their puberty has

1 been delayed.

2 Q. But their development in that regard is not
3 contemporaneous with their peers.

4 Correct?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: In my specific hypothetical
7 some of their development is going to be contemporaneous
8 with their peers. Some of it will not be.

9 ATTORNEY BARHAM: I'm going to show you
10 what we will mark as Exhibit 32. This will be Tab 73.

11 ---

12 (Whereupon, Exhibit 32, Puberty Blockers
13 Document, marked for identification.)

14 ---

15 THE WITNESS: Can I ask a clarifying
16 question, it is 2:32 east coast time, not central.

17 ATTORNEY SWAMINATHAN: Yes.

18 LAW CLERK WILKINSON: Tab 73.

19 BY ATTORNEY BARHAM:

20 Q. This document is a hand out --- or it's from the
21 --- I'm going to butcher the name, Doernbecher
22 Children's Hospital at OHSU from their gender clinic and
23 about puberty blockers document. At the bottom of page
24 three, this document indicates that researchers have not

1 finished studying how safe puberty blockers are in the
2 long-term.

3 Do you agree with that?

4 A. Yeah, I would agree with that.

5 Q. On the next page this document says that because
6 puberty block --- because blocking puberty hormones can
7 weaken your bones, it is best to just take them for just
8 two or three years.

9 Do you agree or disagree?

10 A. That is outside of my scope of expertise.

11 Again, this is a public facing the most like
12 website. I can't be quite certain what the context of
13 this is, but the individualized discussions you're
14 having with patients and families is always going to be
15 more complex than one or two sentences.

16 Q. Do you expect to offer any opinion in this case
17 that puberty blockers administered according to your
18 guidelines are safe and reversible?

19 A. I don't --- I guess I don't understand the
20 question. I provided my expert testimony and my
21 testimony is focused on the mental health effects of
22 various interventions.

23 Q. Okay.

24 Do you anticipate saying anything about the

1 reversibility of puberty blockers?

2 A. Other than what I have already discussed, I
3 don't think so.

4 Q. Let's go to tab 5, I think that's Exhibit 2.
5 And on page 3874, again, about two-thirds down the first
6 column, the Endocrine Society says we still need to
7 study the effects of puberty blocking hormones on
8 gonadal function.

9 Correct?

10 A. Yes.

11 Q. That refers to hormone secretion.

12 Correct?

13 A. Hormone secretion?

14 Q. Uh-huh (yes).

15 A. I'm not sure what you mean by that.

16 Q. Gonadal function refers to the achievement of
17 the production by the gonads of fertile ova or sperm.

18 Correct?

19 ATTORNEY BLOCK: Objection to form and
20 scope.

21 THE WITNESS: I can't speak to the
22 author's intent for how they used that language. It's
23 broader in scope from my perspective than that.

24 BY ATTORNEY BARHAM:

1 Q. Does it include the achievement of production of
2 fertile ova or sperm?

3 A. That is a component, yes.

4 Q. What other components do you have in mind for
5 that term?

6 A. For gonadal development includes size, shape,
7 sexual functioning.

8 Q. On page 31, I want to go to --- have we done
9 Tab 6 yet?

10 ATTORNEY BARHAM: I want to introduce
11 what will be marked as Exhibit 33, this will be Tab 6.
12 These are Endocrine Society guidelines from 2009.

13 LAW CLERK WILKINSON: I don't think I
14 have that.

15 ATTORNEY BARHAM: Maybe we do.

16 LAW CLERK WILKINSON: Six?

17 ATTORNEY BARHAM: Uh-huh (yes).

18 LAW CLERK WILKINSON: Uh-uh (no).

19 BY ATTORNEY BARHAM:

20 Q. We will go back to Tab 5 then, Exhibit 2. Would
21 you agree that if the administration for puberty
22 blockers for gender dysphoria has irreversible effects
23 on brain development, that would be a serious safety
24 problem?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: All risks are graded risk
3 an benefits as well as alternatives for each individual
4 child.

5 BY ATTORNEY BARHAM:

6 Q. But if it had an irreversible affect on brain
7 development that would still be a serious concern,
8 regardless of the gradations that we would have to
9 consider and address it?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: There are a number of
12 interventions that lead to irreversible changes that are
13 beneficial and are not of concern to safety.

14 ATTORNEY BARHAM: All right.

15 Do we have Tab 32?

16 LAW CLERK WILKINSON: That one I have.

17 ATTORNEY BARHAM: This will be Exhibit
18 33, Tab 32 just to make it conducive.

19 ---

20 (Whereupon, Exhibit 33, Endocrine
21 Society's Guidelines, was marked for
22 identification.)

23 ---

24 BY ATTORNEY BARHAM:

1 Q. And if you look on --- at the end of the
2 document where it says for more information, it stated
3 this is a document from the National Institute of Mental
4 Health.

5 Correct?

6 ATTORNEY BLOCK: Objection to form,
7 foundation.

8 THE WITNESS: I have no idea of what the
9 context of this website is or what this is from.

10 BY ATTORNEY BARHAM:

11 Q. But it gives the National Institute of Mental
12 Health's website.

13 Is that correct?

14 A. It does.

15 Q. And it says for more information you can e-mail
16 the National Institute of Mental Health e-mail address.

17 Correct?

18 A. That is correct.

19 Q. And that's a part of the National Institute.
20 Right?

21 A. It is.

22 Q. And the citations it's drawing from articles in
23 1999 and 2000.

24 Correct?

1 A. That is correct.

2 Q. On page one in the middle column, the article
3 describes gray matter at the thinking part of the brain.

4 Do you agree with that description?

5 A. I would describe it as a gross
6 mischaracterization of the complexity of the brain.

7 Q. What is your understanding of the function of
8 the gray matter?

9 A. That is one element of it. I think it is a lot
10 of nuance, I guess is the word that I'm looking for.
11 It's not characterized by that much of a pithy phrase,
12 not of a neuropathologist.

13 Q. The article talks about a second wave of
14 production in gray matter that peaks around age 11 in
15 girls and 12 in boys. And the article refers to that as
16 just prior to puberty. In terms of Tanner stages that
17 would be around Tanner 2 for most boys and girls, would
18 it not?

19 A. That would be Tanner Stage 1.

20 Q. That would be Tanner Stage 1. But by 11 or 12
21 you have already --- by age 12-ish in boys, it's typical
22 for puberty blockers to have been administered.

23 Correct?

24 A. To use the language of this article, the

1 differences in Tanner stages is caused by the, quote,
2 surging sex hormones not the other way around. So it's
3 not about age, but it's the exposure to hormones that
4 causes the Tanner stages to develop.

5 Q. Have you made a study yourself about the timing
6 of brain gray matter development and the puberty
7 hormones in causing that development?

8 A. I have not.

9 Q. Do you have any reason to doubt the timing and
10 nature of development as set out in this National
11 Institute of Health publication?

12 ATTORNEY BLOCK: Objection to form and
13 foundation.

14 THE WITNESS: I only have the context of
15 this article that you've put in front of me for the
16 first time and in this article they describe the brain
17 changes just happening prior to puberty, which is prior
18 to when we would be initiating any interventions
19 medically.

20 BY ATTORNEY BARHAM:

21 Q. And it says though that it is possibly the
22 thickening peaks around 11 or 12, depending on girls and
23 boys and that's possibly related to the influence of
24 surging sex hormones.

1 Correct?

2 A. If that's what it says, yes.

3 Q. Do you know --- have you conducted any studies
4 to determine the effect of administering puberty
5 blockers during the ordinary years of puberty and how
6 that would impact the ordinary development of brain
7 matter in the brain of a child?

8 A. I have not, but it kind of sounds like that is
9 conflating this as a study, which is definitely not.

10 Q. No, I'm just asking if you had conducted any
11 such studies?

12 A. I have not.

13 Q. Are you aware of any such studies?

14 A. There are studies that are ongoing now.

15 Q. That are ongoing.

16 ATTORNEY BARHAM: Okay.

17 I'm going to show you what we marked as
18 Exhibit 34, this will be Tab 33.

19 ---

20 (Whereupon, Exhibit 34, Article by
21 Blakemore, et al., was marked for
22 identification.)

23 ---

24 BY ATTORNEY BARHAM:

1 Q. This is an article by Blakemore, et al.,
2 published in 2010, The Role of Puberty in the Developing
3 Adolescent Brain. On page 929, the article states the
4 ages at which these peaks in gray matter volume were
5 observed correspond to the sexually dimorphic ages
6 gonadarche, I'm mispronouncing that, onset which
7 suggests possible interactions between puberty hormones
8 and gray matter development.

9 Do you agree or disagree with that statement?

10 A. I'm not seeing where you're referring to this.

11 Q. On page 929, first column right above the role
12 of puberty in gray matter development?

13 A. As stated in this study, the changes were
14 observed to correspond to the ages which suggest
15 possible interactions. I have no objection to the idea
16 that there are possible interactions between puberty
17 hormones and gray matter development, but again, outside
18 the field of my expertise.

19 Q. Okay.

20 It also refers to other MRI studies showing a
21 gradual emergence of sexual dimorphisms across puberty.
22 Do you know what sexual dimorphism of the brain means?

23 A. I do.

24 Q. What does it mean?

1 A. Differences that are measurable between folks
2 assigned female and folks assigned male at birth is
3 typically how that is described.

4 Q. On the first page of this document it says
5 throughout adolescence there are changes in the
6 structure and function of the brain, sexual dimorphism
7 in many of these changes suggest possible relationships
8 to puberty.

9 This article is saying that the available
10 evidence suggests sex links puberty hormones to play a
11 role in stimulating brain development; do you agree?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: Certainly I agree that
14 exposure to sex hormone is a part of brain development
15 for all people. We know less about the developing brain
16 for transgender youth.

17 BY ATTORNEY BARHAM:

18 Q. Do you agree this includes a aspects of brain
19 development that differ between healthy males and
20 healthy females?

21 ATTORNEY BLOCK: Objection as to form.

22 THE WITNESS: I don't. I haven't seen
23 any literature that speaks to that specific question.

24 BY ATTORNEY BARHAM:

1 Q. Okay.

2 Let's go back to Exhibit 2, page 3882?

3 ATTORNEY BLOCK: What page was that,
4 Counsel?

5 ATTORNEY BARHAM: 3882.

6 BY ATTORNEY BARHAM:

7 Q. Under the heading side effects, the article
8 indicates that the primary risk of pubertal suppression
9 in GD, gender incongruent adolescents may include,
10 ellipses, unknown effects on brain development, do you
11 see that?

12 A. I see that.

13 Q. And in the first column of 3883 indicates that
14 animal data suggests there may be effects of GnRH
15 analogs on cognitive function.

16 Do you see that?

17 A. I see that.

18 Q. Cognitive function means the ability to think.
19 Correct?

20 A. That is one aspect of cognitive functioning.

21 Q. Do you tell parents and patients that the
22 Endocrine Society has indicated that there are unknown
23 effects on brain development related to the use of
24 puberty blocking hormones?

1 A. I typically use language that is more similar to
2 how they actually described it in this article which is
3 to say that it may have unknown effects on brain
4 development.

5 Q. Okay.

6 ATTORNEY BARHAM: Let's go to Tab 32,
7 which we have already looked at and that is Exhibit.

8 LAW CLERK WILKINSON: Exhibit 33.

9 BY ATTORNEY BARHAM:

10 Q. Exhibit 33?

11 ATTORNEY GREEN: Travis, this is Roberta
12 Green. I'm sorry to interrupt. I wondered if you
13 wouldn't mind keeping your voice up I'm just having
14 trouble hearing. No doubt it's me but it'd be great.
15 Thank you.

16 ATTORNEY BARHAM: It may also be where
17 I'm located in the room, but I'm getting it from enough
18 people, so I appreciate the reminder.

19 VIDEOGRAPHER: Counsel, did you say
20 Exhibit 33.

21 ATTORNEY BARHAM: Exhibit 33.

22 BY ATTORNEY BARHAM:

23 Q. Page two at the top refers to the gray matter
24 --- or the white matter and how research purports a wave

1 of white matter growth that begins at the front of the
2 brain in early childhood, moves to the side after
3 puberty, striking growth spurts can be seen from age 6
4 to 13 in areas connecting brain regions specialized for
5 language and understanding special relationships. Ages
6 11, 12 and 13 are sort of the heart and center of
7 puberty.

8 Correct?

9 ATTORNEY BLOCK: Objection to form.

10 THE WITNESS: It depends upon the child.

11 BY ATTORNEY BARHAM:

12 Q. In general?

13 ATTORNEY BLOCK: Same objection.

14 THE WITNESS: I don't want it to be like
15 I'm parsing this out, but it's really important. We
16 can't apply population based data onto an individual and
17 make conclusions about it.

18 BY ATTORNEY BARHAM:

19 Q. But we can assess population-based data as to
20 when puberty is generally occurring and generally it's
21 occurring around the ages of 11 to 13?

22 A. I would agree with the statement that puberty is
23 generally occurring within those age ranges, yes.

24 Q. And that is also approximately when puberty

1 blocking hormones are being prescribed.

2 Is that true?

3 A. It depends upon the individual.

4 Q. But generally around age 12 is what you
5 indicated earlier.

6 Correct?

7 A. It really depends upon the individual. To
8 clarify, it's based upon Tanner stage as one element,
9 age has one element, psychosocial functioning has
10 another, family choices. It's a calculus of the risks,
11 benefits and alternatives that guide when we decide to
12 intervene if we decide to intervene.

13 Q. So you would agree that a teenage brain and
14 cognitive development across puberty is a very
15 complicated area and one that's not easily understood.

16 Correct?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: Yes, adolescent brain
19 development is a complicated phenomenon for sure. I
20 have no objection to that.

21 BY ATTORNEY BARHAM:

22 Q. Is that an area of your professional research
23 and investigation?

24 A. Specifically on neuroscience with regard to

1 adolescent development, no, it is not.

2 ATTORNEY BARHAM: Let's go to Tab 8.

3 THE WITNESS: I need to take another
4 bathroom break.

5 ATTORNEY BARHAM: Let's just take a break
6 now. Let's go off the record.

7 VIDEOGRAPHER: Going off the record. The
8 current time reads 2:53 p.m.

9 OFF VIDEOTAPE

10 ---

11 (WHEREUPON, A SHORT BREAK WAS TAKEN.)

12 ---

13 ON VIDEOTAPE

14 VIDEOGRAPHER: Back on the record. The
15 current time reads 3:00 p.m.

16 BY ATTORNEY BARHAM:

17 Q. Are you an expert on suicide and suicidality?

18 A. I guess I don't know exactly how to qualify that
19 response. I know more than most people about suicide
20 and suicidality, yes.

21 Q. Have you made any systematic study of suicide
22 among the thousands treated at the NYU Gender and
23 Sexuality Service?

24 A. I have not.

1 Q. Have you made any systematic studies of suicide
2 among the thousands treated at the Lurie Children's
3 Hospital here in Chicago?

4 A. I have a study ongoing.

5 Q. Has that study generated any preliminary results
6 yet?

7 A. It has not.

8 Q. Have you made any systemic studies of suicide
9 among the thousands you've treated at the Gender Variant
10 Youth and Family Network?

11 A. That is not a clinical service.

12 Q. Are you aware that suicide for any reason is
13 extremely rare among children younger than 15?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: I would disagree with that
16 as a statement. It's among one of the top causes of
17 death for children of ages 10 to 15.

18 BY ATTORNEY BARHAM:

19 Q. And what's your basis for saying that?

20 A. The CDC data.

21 Q. Did you cite that data in your report?

22 A. I did not.

23 Q. You're not offering an opinion that BPJ faced a
24 high suicide risk unless put on puberty blockers.

1 Correct?

2 A. I am not.

3 Q. Has any responsible health authority or
4 organization made a claim that the use of puberty
5 blockers relate to suicide?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: I mean, that's a big list.
8 I don't think any that I'm aware of have made the claim,
9 especially when it comes to causation.

10 BY ATTORNEY BARHAM:

11 Q. In paragraph 19 of your report you refer to
12 gender-affirming hormone therapy and you make similar
13 statements in paragraphs 39, 40, 41 and 42. What do you
14 mean by gender affirming hormone therapy?

15 A. Typically speaking when I'm referring to
16 gender-affirming hormone therapy, these are hormones
17 that are aligned with the gender identity.

18 Q. So that means the administration of cross sex
19 hormones.

20 Is that correct?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: Yeah. I mean, I think I
23 would call them gender-affirming hormones. That is how
24 typically they are referred to in the literature.

1 BY ATTORNEY BARHAM:

2 Q. So this means that you would administer
3 testosterone to natal females.

4 Correct?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: I personally would not,
7 but ---.

8 BY ATTORNEY BARHAM:

9 Q. Cross sex hormones or gender-affirming hormones
10 refers to the administration of testosterone to natal
11 females.

12 Correct?

13 A. Or assigned females at birth, yes, that's
14 correct.

15 Q. And it means the administration of testosterone
16 suppression of estrogen for natal males.

17 Correct?

18 ATTORNEY BLOCK: Objection to form.

19 THE WITNESS: Assigned male at birth,
20 yes.

21 BY ATTORNEY BARHAM:

22 Q. You mean assigned males at birth?

23 A. Yes. Is that what I not said? Sorry.

24 Q. What is your role in the administration of cross

1 sex hormones?

2 A. It depends on the child and the family, but my
3 role is most often as a mental health professional who
4 is either doing the assessment or providing care for the
5 co-occurring psychiatric disorders that are present in
6 that individual child.

7 Q. Cross sex hormones prevent rather than enable an
8 adolescent from becoming capable of reproducing
9 sexually.

10 Correct?

11 ATTORNEY BLOCK: Objection to the form.

12 THE WITNESS: That's not something that I
13 can answer. That's out of the scope of my expertise.

14 BY ATTORNEY BARHAM:

15 Q. You lack an understanding of the effects of
16 administering cross sex hormones?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: I would disagree with that
19 statement.

20 BY ATTORNEY BARHAM:

21 Q. So my question is what is the effect of
22 administering cross sex hormones on an adolescent's
23 ability to develop and become capable of reproducing
24 sexually?

1 A. It's a highly complicated question that depends
2 upon a lot of factors that are above the scope of my
3 testimony here. As an example, there are many adult
4 transgender men who become pregnant despite being on
5 testosterone for many years.

6 Q. And what studies are you referencing that
7 support that statement?

8 A. I'm not referencing any studies to this. I'm
9 referencing personal experiences.

10 Q. Okay.

11 Cross sex hormones cannot cause an adolescent
12 to develop the genitalia associated with his or her ---
13 his or her desired transgender identity.

14 Correct?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: That's correct.

17 BY ATTORNEY BARHAM:

18 Q. Cross sex hormones also cannot achieve male
19 height in a natal female.

20 Correct?

21 ATTORNEY BLOCK: Objection to form.

22 THE WITNESS: I would defer to my
23 endocrine colleagues on that answer.

24 BY ATTORNEY BARHAM:

1 Q. Can cross sex hormones change the hip and leg
2 configuration in a natal male to match that of a natal
3 female?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: I would defer to my
6 endocrine colleagues on that question.

7 ATTORNEY BARHAM: Let's go to Tab 77.
8 This is probably new.

9 LAW CLERK WILKINSON: Yes.

10 ATTORNEY BARHAM: This is an article by
11 Guss, et al. in 2015, entitled Transgender and Gender
12 Non-Conforming Adolescent Care. This will be
13 Exhibit 35.

14 ---
15 (Whereupon, Exhibit-35, Article by Guss,
16 et al., was marked for identification.)

17 ---

18 BY ATTORNEY BARHAM:

19 Q. Are you familiar with the authors?

20 LAW CLERK WILKINSON: I'm sorry. I gave
21 you the wrong one. Here is the right one.

22 THE WITNESS: I know Dr. Shumer. And we
23 read something by Katz-Wise earlier. I don't know Carly
24 Guss.

1 BY ATTORNEY BARHAM:

2 Q. Page four of this document indicates that if a
3 patient is on cross sex hormones it's important to
4 remind them that the side effects may be infertility.

5 Is that correct?

6 A. Where are you pointing to?

7 Q. The top of page four.

8 A. Yes.

9 Q. Do you agree with that statement?

10 A. I agree.

11 Q. Do you know of any long-term studies that will
12 change to what extent infertility caused by taking cross
13 sex hormones can be reversed later in life?

14 A. There are ongoing studies now, but I'm not aware
15 of any that have published anything.

16 Q. Have you studied the literature regarding mental
17 health problems in adults resulting from sterility?

18 ATTORNEY BLOCK: Objection to form.

19 THE WITNESS: I don't know what you mean
20 by studied. I don't think probably more than any
21 cursory manner.

22 BY ATTORNEY BARHAM:

23 Q. The use of cross sex hormones to affirm a
24 transgender identity is an off-label use.

1 Correct?

2 ATTORNEY BLOCK: Objection to
3 terminology.

4 THE WITNESS: If by off label you mean
5 off label for the FDA?

6 BY ATTORNEY BARHAM:

7 Q. Yes.

8 A. Yeah, as far as I know. Again, I'm not
9 prescribing these medications as a psychiatrist.

10 Q. Earlier you mentioned that some of your
11 patients, some trans --- some women --- natal females
12 who identify as male have been able to become pregnant.
13 Do you recall that testimony?

14 A. I did not say anything about my patients, I said
15 those were personal experiences.

16 Q. Personal experiences. I'm sorry. I assumed it
17 was patients, so thank you for that correction. I would
18 like to show you Tab 81. This is going to be an article
19 by Moseson, et al. in 2020, entitled Pregnancy
20 Intentions and Outcomes, tab 81 for those at home and
21 Exhibit 36 for the record.

22 --

23 (Whereupon, Exhibit-36, Article by

24 Moseson, et al., was marked for

1 identification.)

2 ---

3 BY ATTORNEY BARHAM:

4 Q. Are you familiar with this study?

5 A. Certainly not the details of it. This is the
6 first time I'm recalling looking at it.

7 Q. Are you aware of any other studies regarding the
8 ability of individuals taking cross sex hormones to
9 become pregnant?

10 A. There are a number of ongoing studies that are
11 looking into those questions, yes.

12 Q. If you look at Table 3 on page number 36, this
13 table indicates there were 79 pregnancies among the
14 respondents who have ever used testosterone.

15 Do you see that?

16 A. Yes.

17 Q. And there were 342 among those who have never
18 used testosterone.

19 Do you see that?

20 A. I see that.

21 Q. But only 15 of these pregnancies occurred after
22 initiating testosterone. Is that correct? And I'm
23 referencing page 33 when I say that, at the bottom of
24 page 33.

1 ATTORNEY BLOCK: Where is this on page
2 33?

3 ATTORNEY BARHAM: The very last line on
4 page 33 extending over onto page 35.

5 THE WITNESS: I see on Table 2 the number
6 of pregnancies after initiating testosterone was 15.

7 BY ATTORNEY BARHAM:

8 Q. So the other 337 of the pregnancies tell us
9 nothing about the impact of testosterone on female
10 fertility and the possible impact of birth defects.

11 Correct?

12 A. Well, the question about fertility certainly
13 doesn't speak to us being able to understand it more
14 based upon the data points. And without reading the
15 article I don't know if the author said anything about
16 birth defects.

17 Q. On page 35 it indicates that 2 of the 15 --- or
18 4 of the 15 pregnancies that started while taking
19 testosterone half of them ended in miscarriage.

20 Correct?

21 A. Yes.

22 Q. One ended in abortion and one was not reported.

23 Correct?

24 A. I don't see where that is.

1 Q. It's the same line. Two of these four
2 pregnancies ended in miscarriage, parentheses, one ended
3 in abortion in the outcome and testosterone duration for
4 the other four were not reported?

5 A. Yes.

6 Q. Okay.

7 And there is no data given on the other outcome
8 of the other 11 pregnancies. So this article does not
9 document a single live birth to a natal female at any
10 time after taking testosterone.

11 Correct?

12 ATTORNEY BLOCK: Objection to form. And
13 give him a chance to read, please.

14 THE WITNESS: I would really have to read
15 the article quite closely to agree with that. I'm not
16 seeing the text in this article to support that. In the
17 Pregnancy Intentions and Outcomes, as I'm reading it, it
18 discusses what the potential outcomes are, but it didn't
19 parse those into who had testosterone before or after,
20 so I'm not sure.

21 BY ATTORNEY BARHAM:

22 Q. Okay.

23 Let me shift gears and turn to paragraph 37 of
24 your report. There you indicate --- you state that

1 there is no evidence supporting Dr. Levine's speculation
2 that allowing prepubertal children to sexually
3 transition puts children on a conveyor belt to becoming
4 transgender adolescents and adults. And you say
5 evidence shows that prepubertal children who are likely
6 to have a stable transgender identity into adolescence
7 are the children who are most likely to articulate a
8 strong and consistent need to socially transition.

9 Do you see that?

10 A. I see that.

11 Q. And in footnote 11 you cite an article by
12 Steensma published in 2013.

13 Is that correct?

14 A. That's correct.

15 ATTORNEY BARHAM: I will show you what
16 we're going to mark as Exhibit 37, Tab 120, and I will
17 also show you Tab 121, which is Exhibit 38.

18 ---

19 (Whereupon, Exhibit-37, Article by
20 Steensma, was marked for
21 identification.)

22 (Whereupon, Exhibit-38, Analysis, was
23 marked for identification.)

24 ---

1 BY ATTORNEY BARHAM:

2 Q. Tab 120, Exhibit 37, is the Steensma article
3 that you cited in footnote 11 of your report.

4 Is that correct?

5 A. That is correct.

6 Q. Let's look at Table 1 on page 584. And it gives
7 --- in the first four columns it gives numbers on
8 persistence and desistance among the study subjects.
9 And about halfway down it delineates how many of the
10 persisting boys and girls and desisting boys and girls
11 had a childhood diagnosis of gender identity disorder.

12 Correct?

13 A. Correct.

14 Q. And it also breaks down how many were
15 subthreshold. I'm presuming that means for gender
16 identity disorder.

17 Correct?

18 A. That is correct.

19 Q. So according to Table 1, 91.3 of the 23
20 persisting boys had gender identity disorder.

21 Correct?

22 A. Correct.

23 Q. So that means about 21 of the 23 persisting boys
24 had that condition.

1 Correct.

2 A. Correct.

3 Q. And according to Table 1, 95.8 of the 24
4 persisting girls had the same diagnosis or 23 of the 24.
5 Correct?

6 A. That's correct.

7 Q. And according to the same Table, 39.3 of the 56
8 desisting boys had that diagnosis.

9 Correct?

10 A. That is correct.

11 Q. So that's 22 of the 56.

12 Correct?

13 A. I'll take your word for the math.

14 Q. Well, you can see it on Exhibit-121 (sic). On
15 Table 1, 58.3 of the 24 desisting girls had gender
16 identity disorder or 14 of the 24.

17 Correct?

18 A. Correct.

19 Q. Do you see any reason to dispute the figures set
20 forth on Exhibit --- on Tab 121, Exhibit 39 ---
21 Exhibit 38?

22 A. No, I have no reason to ---.

23 ATTORNEY SWAMINATHAN: I think he is
24 looking at the wrong document.

1 BY ATTORNEY BARHAM:

2 Q. I'm talking about this.

3 A. Got it. So this is a transposition from
4 Table 1?

5 Q. Correct.

6 A. I mean, I'm going to have ---.

7 ATTORNEY BLOCK: Just objection. I'm
8 sorry, can we put on the record what this document is?
9 Is it a reprint of what's in the Steensma or is it new
10 analysis that ---?

11 ATTORNEY BARHAM: Exhibit 38 is an
12 analysis of the Steensma 2013 article that is
13 Exhibit 37.

14 ATTORNEY BLOCK: Thank you. And is
15 there an author of the analysis?

16 ATTORNEY BARHAM: I'm sorry. Say that
17 again.

18 ATTORNEY BLOCK: Is there an author of
19 this analysis?

20 ATTORNEY BARHAM: Yes, it was me.

21 BY ATTORNEY BARHAM:

22 Q. So according to the figures that have been
23 calculated from table one of the Steensma article, 80
24 children --- of the 80 children who had gender identity

1 disorder, 44 persisted and 36 desisted.

2 Is that correct?

3 ATTORNEY BLOCK: Objection to give the
4 witness a chance to see it on his own what the figures
5 are.

6 THE WITNESS: I'm not sure I understand
7 what your question is.

8 BY ATTORNEY BARHAM:

9 Q. Of the children with the --- the 80 children who
10 had a diagnosis of gender identity disorder, 44
11 persisted and 36 desisted.

12 Is that correct?

13 A. I would have to do the math myself for me to say
14 yes to that, but it's about right.

15 Q. So according to Steensma figures, of the
16 children with the strongest transgender identity as
17 children 55 percent persisted and 45 percent desisted.

18 Correct?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: Again, I would have to run
21 those numbers myself in order to --- unless it's
22 referred to already in the article, but that sounds
23 about right.

24 BY ATTORNEY BARHAM:

1 Q. In footnote 12 of your report, paragraph 37, you
2 cite an article by Rae saying for the proposition that
3 socially transitioning before puberty did not increase
4 children's cross gender identification and deferring
5 transgender did not decrease cross gender
6 identification.

7 Is that correct?

8 A. That is correct.

9 ATTORNEY BARHAM: All right.

10 Let's turn to Tab 108. This will be
11 Exhibit 39, and it will be an article by Rae, et al.
12 published in 2019, Predicting Early Childhood Gender
13 Transitions.

14 ATTORNEY BLOCK: It's 2:22 central time.
15 So the witness has to take a break at 2:30?

16 THE WITNESS: I can do 2:45.

17 ---

18 (Whereupon, Exhibit 39, Article by Rae,
19 et al., marked for identification.)

20 ---

21 BY ATTORNEY BARHAM:

22 Q. Exhibit 39 is the article that you cited in
23 footnote 12 of your report.

24 Is that correct?

1 A. That's correct.

2 Q. On page 679 the author indicates that
3 replication of this affect is muted preferably from
4 longitudinal study comparing a single group of children
5 before and after transition.

6 Correct?

7 A. That's correct.

8 Q. And the authors also indicate that they tested a
9 sample skewed by race, class, parental that education
10 and political affiliation that may or may not affect the
11 children that are socially transitioning now or in the
12 future.

13 Correct?

14 A. That is correct.

15 Q. And they also indicate that follow-up occurred
16 only two years after testing and some of the children
17 who had not transitioned could transition in the future
18 and some who had transitioned could not revert in the
19 future.

20 Correct?

21 A. Correct.

22 Q. And they indicated that there sample is likely
23 an over estimate of how many gender conforming children
24 in the general population will socially transition.

1 Correct?

2 A. Where is that in the article?

3 Q. Second column of page 679.

4 A. Yes.

5 Q. Same column they also indicate that they relied
6 on a convenient sample of individuals recruited through
7 lists and events serving transgender children and gender
8 non-conforming children.

9 Correct?

10 A. That is correct.

11 Q. Let's go back to Tab 5, which is Exhibit 2.
12 Page 3879, the Endocrine Society indicates that if
13 children have completely socially transitioned they have
14 my greater difficulty returning to the original gender
15 on entering puberty.

16 Is that correct?

17 A. That's correct. It says it there, but that's
18 based on supposition.

19 Q. Footnote 40 --- reference number 40 supposition
20 --- reference number 40 is an article by Steensma, et
21 al., published in 2011.

22 Are you saying that that's a supposition?

23 ATTORNEY BLOCK: Objection to form.

24 THE WITNESS: No, I'm saying that the

1 part of that article that refers to the theoretical risk
2 is based not on any data that was collected by the
3 researchers in that study.

4 BY ATTORNEY BARHAM:

5 Q. The Endocrine Society also indicates that the
6 social transition has been found to contribute to the
7 likelihood of persistence.

8 Is that correct?

9 A. That is a misstating of Dr. Steensma.

10 Q. That is what the Endocrine Society has
11 concluded.

12 Correct?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: That is what they have
15 written here in the article you presented, yes.

16 ATTORNEY BARHAM: Let's go to Tab 97
17 number ---.

18 LAW CLERK WILKINSON: Exhibit 16.

19 BY ATTORNEY BARHAM:

20 Q. Exhibit Number 16, and we are going to be
21 looking at the sixth page of this document. And Dr.
22 D'Angelo, et al. article indicates that since almost all
23 the children treated with puberty blockers proceeded to
24 cross sex hormones concerns have been raised that

1 puberty blockers may consolidate gender dysphoria in
2 young people putting them on a lifelong path of
3 biomedical invention.

4 Is that correct?

5 ATTORNEY BLOCK: Object is to form.

6 THE WITNESS: Can you show me where that
7 is on this page?

8 BY ATTORNEY BARHAM:

9 Q. The first column on the second paragraph. The
10 second column.

11 ATTORNEY TRYON: Jake, can you scroll
12 down a bit?

13 THE WITNESS: I would not agree with how
14 you asked that question, I guess. Can you repeat it or
15 clarify?

16 BY ATTORNEY BARHAM:

17 Q. I just was reading what it said. They indicate
18 in this section additionally since almost all of the
19 children treated with puberty blockers proceed to cross
20 sex hormones citing de Vries 2014, concerns have been
21 raised at puberty blockers may consolidate gender
22 dysphoria in young people, putting them on a lifelong
23 path of biomedical interventions?

24 A. It's bit of a logical leap and also just

1 incorrect. The de Vries study specifically was looking
2 at the children in the Amsterdam clinic, which is not
3 broadly applicable to other gender clinics across the
4 rest of the world.

5 Q. But you relied upon de Vries 2014 article in
6 your report as well, didn't you?

7 A. I agree. Yeah.

8 Q. So there are professionals who have raised these
9 concerns and hold the concerns that social transitioning
10 cannot change the outcome for a child.

11 Is that correct?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: I think there's two
14 different questions. The first question is, do I agree
15 with this statement that almost all children treated
16 with puberty blockers proceed to cross sex hormones?
17 That is not data that we have nor does this article
18 point to data other than the Dutch clinic that has a
19 very specific protocol.

20 The question about whether social
21 transition changes a child's trajectory is a different
22 question. It is a question that the Dutch have raised
23 as a possibility, but has not, I have not seen any
24 literature that provides evidence for that.

1 BY ATTORNEY BARHAM:

2 Q. But you will recognize that there are some
3 researchers in the field who have raised these concerns
4 and do hold these concerns.

5 Correct?

6 A. There are researchers in the field who ask these
7 questions, yes.

8 ATTORNEY BARHAM: Let's go to Tab 38.

9 ATTORNEY TRYON: How late are we going in
10 this session; until 2:30 or 2:45?

11 ATTORNEY BARHAM: The witness has
12 indicated he can go to 2:45.

13 ATTORNEY TRYON: Okay.

14 ATTORNEY BARHAM: Exhibit 40 is an
15 article by Carmichael, et al. 2021, Short-term Outcomes
16 of Pubertal Suppression in a Selected Cohort of 12 to 15
17 year old Young People. If you'll turn to page 12.

18 ---

19 (Whereupon, Exhibit 40, Article by
20 Carmichael, et al., was marked for
21 identification.)

22 ---

23 BY ATTORNEY BARHAM:

24 Q. Are you familiar with this paper?

1 A. I have not read through this paper, yet.

2 Q. The lead authors are associated with the
3 Tavistock?

4 A. That is correct.

5 Q. And that's part of the National Health Services
6 of the UK.

7 Is that correct?

8 A. That is correct?

9 Q. And it's the leading and most respected clinic
10 in the UK.

11 Correct?

12 A. That I can't answer.

13 Q. If you'll look at page 12, the authors indicate
14 that one young person decided to stop GnRHa and did not
15 start cross sex hormones due to continued uncertainty
16 and concerns about the side effects of cross sex
17 hormones, the remaining 43 or 98 percent elected to
18 start cross sex hormones.

19 Is that correct?

20 A. Correct.

21 Q. So the vast majority of these children who
22 received puberty blockers went onto take cross sex
23 hormones.

24 Correct?

1 A. That is correct.

2 Q. Would you agree that the majority of children
3 who receive puberty blockers go on and take cross sex
4 hormones?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: That is not a question
7 that we have an answer to based upon the literature. A
8 majority of patients with gender dysphoria that are
9 prescribe puberty blockers are not involved in clinical
10 care at either the Tavistock clinic or the Amsterdam
11 clinic.

12 BY ATTORNEY BARHAM:

13 Q. Is it --- in your practice, do the majority of
14 children who receive puberty blockers for gender
15 dysphoria go on to take cross sex hormones?

16 A. Based upon the demographic of the patients that
17 I'm seeing, particularly in Chicago, yes, but I'm not
18 seeing the younger kids as much as I did in New York.

19 Q. So as a practical and ethical matter the
20 decision to put a child on puberty blockers must be
21 considered as equivalent of a decision to put the
22 children on cross sex hormones with all of the
23 considerations and full consent obligations listed in
24 that decision.

1 Correct?

2 ATTORNEY BLOCK: Objection to form.

3 THE WITNESS: No.

4 BY ATTORNEY BARHAM:

5 Q. Why do you say --- why do you disagree?

6 A. Inherent in the informed consent process is a
7 specific discussion of the risk benefits and
8 alternatives of a specific intervention. Hormones are
9 not puberty blockers, it's a separate discussion.

10 Q. Even though the vast majority according to the
11 research and according to your testimony go onto take
12 cross sex hormones?

13 ATTORNEY BLOCK: Objection to form and
14 mischaracterizes testimony.

15 THE WITNESS: A description of the
16 potential trajectories of development is a part of the
17 discussion in an informed consent process for the
18 engagement with puberty suppression agents. It's not
19 the same as informed consent process discussion around
20 the use of hormones at that time.

21 BY ATTORNEY BARHAM:

22 Q. So when you're having an informed consent
23 discussion surrounding the decision to start puberty
24 blockers, do you discuss with parents and patients the

1 dangers associated with cross sex hormones?

2 A. This is going to be very individualized
3 discussions that we have with families. It's a very
4 momentous decision to make this kind of treatment
5 choice. The potential trajectories are all discussed
6 and there's risk to everything. I don't think it is
7 useful to use the term dangers in the context of medical
8 care but it's about weighing risks of interventions but
9 also weighing the risks of non-intervening. And it's
10 appropriate to have those discussions about what those
11 potential outcomes may be with each individual kid.

12 Q. How do you get informed consent from a child?

13 A. You get assent from a child, but you get
14 informed consent from a parent.

15 Q. How do you get --- how can a child even begin to
16 understand the implications of starting puberty blockers
17 and then potentially going to cross sex hormones, the
18 effects that that may have on the fertility when the
19 child is 12-ish?

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: Well, I have a skewed
22 perspective here because of the work that I do, but
23 there are 12-year-olds who are often much more capable
24 of having that kind of informed decision than many

1 adults that I have encountered, which is to say it's an
2 individualized assessment based upon multiple things,
3 including the cognitive status of the child, their
4 capacity to engage back and forth and have an open
5 discussion and a realistic discussion about the
6 potential benefits, risks and alternatives in specific
7 intervention.

8 BY ATTORNEY BARHAM:

9 Q. Is it your position that most 12-year-olds have
10 a better understanding or a better capability of making
11 decisions about their long-term fertility than adults?

12 A. It is not my position and I will reflect that
13 that was a statement meant in jest, but it does reflect
14 some sense of reality in terms of the maturity level of
15 12-year-olds, not speaking to the maturity level of most
16 20-somethings in the world.

17 ATTORNEY BARHAM: I think this would be a
18 good time to pause for your appointment and give you a
19 few moments before that starts, so we'll go off the
20 record.

21 VIDEOGRAPHER: Going off the record. The
22 current time reads 3:37 p.m.

23 OFF VIDEOTAPE

24 ---

1 (WHEREUPON, A SHORT BREAK WAS TAKEN.)

2 ---

3 ON VIDEOTAPE

4 VIDEOGRAPHER: Back on the record the
5 current time reads 4:31 p.m.

6 ATTORNEY BARHAM: All right. Let's go to
7 Tab 16, which will be Exhibit Number 41.

8 ---

9 (Whereupon Exhibit 41, Washington Post
10 Article, was marked for identification.)

11 ---

12 BY ATTORNEY BARHAM:

13 Q. This is will be a Washington Post article from
14 January 10, 2022. Are you aware of the 2021/2022 season
15 swimming events surrounding the University of
16 Pennsylvania's swimmer Lia Thomas?

17 ATTORNEY BLOCK: Objection to scope.

18 THE WITNESS: I have not been following
19 closely, but I've heard about it.

20 BY ATTORNEY BARHAM:

21 Q. Okay.

22 On page three of Exhibit 41, the article
23 references that Lia Thomas in her first year in the
24 Women's Division after more than a year of testosterone

1 suppression set the Women's Division record in two
2 events.

3 Do you see that?

4 A. I see that, yes.

5 Q. And Lia Thomas beat the best time of women's
6 Olympian Torri Huske in the 200 freestyle.

7 Do you see that?

8 A. I see that.

9 ATTORNEY BLOCK: I just want to note an
10 objection to foundation, that there's no URL. This
11 appears to be cut and pasted. So I'm just noting that
12 for the record.

13 ATTORNEY BARHAM: And I would note For
14 the record that there is an URL at the bottom of page
15 --- at the bottom of each page.

16 ATTORNEY BLOCK: Thanks. It's not
17 visible from what's on the screen.

18 ATTORNEY BARHAM: Okay.

19 Just trying to be clear.

20 BY ATTORNEY BARHAM:

21 Q. Is it your position that it is fair for Lia
22 Thomas to compete in the Women's Division of swimming?

23 ATTORNEY BLOCK: Objection to scope.

24 THE WITNESS: I don't have an opinion on

1 the fairness.

2 BY ATTORNEY BARHAM:

3 Q. Do you believe that it's beneficial to Lia
4 Thomas' mental health to compete in the Women's
5 Division?

6 A. I couldn't tell you that unless I had evaluated
7 Lia Thomas herself.

8 Q. But it's your opinion as expressed in
9 paragraph 52 of your report that no reasonable mental
10 health professional could conclude that the Act is
11 anything but harmful to the mental health of transgender
12 youth.

13 Is that correct?

14 A. I would say youth as a class, yes, that is
15 correct, but the specific details of that impact are not
16 going to be known and I wouldn't care to surmise on it
17 for a specific individual that is not under my care.

18 Q. Okay.

19 But it's your position that allowing a
20 transgender --- or allowing natal males to compete in
21 the Women's Division if they are gender dysphoric is
22 beneficial to their mental health, in general.

23 Correct?

24 ATTORNEY BLOCK: Objection to terminology

1 and form.

2 THE WITNESS: In my report, excluding
3 transgender youth can be harmful to their mental health.

4 BY ATTORNEY BARHAM:

5 Q. And when you say excluding them you mean
6 excluding them from competition consistent with their
7 gender identity.

8 Is that correct?

9 A. That is correct.

10 ATTORNEY BARHAM: All right.

11 I want to show you Tab 17 now. This will
12 be Exhibit-42.

13 ---

14 (Whereupon, Exhibit 42, Out Sports
15 Article, was marked for identification.)

16 ---

17 BY ATTORNEY BARHAM:

18 Q. Have you read about Iszac Henig before today?

19 A. I have not.

20 Q. This is an article from Out Sports published on
21 January 9th, 2022, by Karleigh Webb entitled Trans
22 swimmers Lia Thomas and Iszac Henig went head-to-head in
23 the pool, each getting wins. Are you aware that Iszac
24 Henig is a biological female who identifies as male?

1 A. I have not heard of Iszac Henig until today at
2 least by name.

3 Q. Do you see on the first page of this article the
4 article reads Henig, a trans man competing on the
5 women's swimming team at Yale?

6 A. I see that, yes.

7 Q. So in this event a biological male identifies as
8 female, Lia Thomas, competed against a biological female
9 who identifies as male, Iszac Henig, in the women's
10 competition?

11 ATTORNEY BLOCK: Objection can you give
12 him a chance to read the article. He's never seen or
13 heard of this before?

14 THE WITNESS: It seems that is what
15 stipulated in the article.

16 BY ATTORNEY BARHAM:

17 Q. Okay.

18 According to the terminology you prefer, do you
19 consider Henig to be anything other than a man?

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: I will typically ask the
22 individuals that I'm working with or engaging with how
23 they choose to define their own sense of labels. Not
24 knowing Iszac I can't speak for him.

1 BY ATTORNEY BARHAM:

2 Q. Okay.

3 But according to the terminology that you've
4 been using Iszac would be an individual assigned female
5 sex at birth and identifying as male.

6 Correct?

7 A. Again, I don't see ---

8 Q. Henig a trans man?

9 A. --- a description of his words to describe his
10 identity, so I can't say how he identifies himself, but
11 it appears through that that's how --- that is the
12 implication of the article at least.

13 Q. In the article it uses masculine pronouns to
14 refer to Henig.

15 Correct?

16 A. Yes.

17 Q. Do you think it'd beneficial to Henig's mental
18 health to compete on the women's team?

19 A. Again, I can't answer that unless I had
20 evaluated Henig myself.

21 Q. In general, if you have a transgender individual
22 who wants to compete on the team consistent his or her
23 biological sex, do you think it's beneficial to his or
24 her mental health to be allowed to do so?

1 ATTORNEY BLOCK: Objection to form.

2 THE WITNESS: Again, this is an
3 individualized discussion that you have with patients.
4 With the patients that I've had I have had patients who
5 would be harmed by having to compete with the cohort of
6 kids who were aligned with their sex assigned at birth.

7 BY ATTORNEY BARHAM:

8 Q. I understand your position about kids who are
9 forced to do something, what about kids who want to
10 compete with that same cohort, do you think it's
11 beneficial to allow them to compete as they see fit?

12 A. As a mental health professional working with
13 kids and families, it really is an individualized
14 discussion. There is not going to be a specific answer
15 that's universal for all kids.

16 Q. Do you believe that if Henig were prevented from
17 competing with the women's team as desired, that it
18 could be harmful to Henig's mental health ---

19 ATTORNEY BLOCK: Objection to form.

20 BY ATTORNEY BARHAM:

21 Q. --- possibly?

22 A. I can't speak to the specifics about a person
23 that I've never evaluated.

24 Q. If it is harmful to someone's mental health to

1 be prevented from participating in athletics on a team
2 consistent with their gender identity, could it be
3 harmful to their mental health to be prevented from
4 competing on a team consistent with their biological sex
5 if they so wanted to?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: I think there's a whole
8 host of hypotheticals that could potentially be
9 possible.

10 BY ATTORNEY BARHAM:

11 Q. And that is one of them?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: That's possible.

14 ATTORNEY BARHAM: Okay.

15 BY ATTORNEY BARHAM:

16 Q. In paragraph 34 of your report you write a
17 recent study found people who reported experiencing
18 those conversion efforts were more likely to report an
19 attempted suicide, especially those who reported
20 receiving such therapy in childhood.

21 Do you see that?

22 A. I see that.

23 Q. And there we are talking about conversion
24 therapy.

1 Is that correct?

2 A. We're talking specifically about the study
3 participants on perceptive perceptions of conversion
4 therapy.

5 Q. But that's what's meant by those conversion
6 efforts.

7 Correct?

8 A. Correct.

9 Q. In footnote six you cite an article by Turban
10 published in 2020.

11 Is that correct?

12 A. That is correct.

13 ATTORNEY BARHAM: All right.

14 I'm going to show you Tab 113, which will
15 be Exhibit 43.

16 ---

17 (Whereupon, Exhibit 43, Article by
18 Turban, et al., was marked for
19 identification.)

20 ---

21 BY ATTORNEY BARHAM:

22 Q. This is an article published by Turban, et al.
23 published in 2020, it's entitled Association Between
24 Recalled Exposure to Gender Identity Conversion Efforts

1 and Psychological Distress and Suicide Attempts Among
2 Transgender Adults. This is the article that you cited
3 in your report.

4 Is that correct?

5 A. That is correct.

6 Q. And this is the article cited in footnote six as
7 support for the proposition that studies that found that
8 people who reported conversion efforts are more likely
9 to have reported suicide.

10 Correct?

11 A. That's correct.

12 Q. On page two of this article the authors --- and
13 by this article I'm referring to Exhibit 43. The
14 authors note that they rely upon data from the National
15 Center for Transgender Quality and its 2015 transgender
16 survey.

17 Correct?

18 A. That is correct.

19 Q. On page eight of this document, the authors
20 admit that it is cross sectional study designed
21 precludes determination of causation.

22 Correct?

23 A. I don't have page numbers. Which one is that?

24 Q. It's the one with strengths and limitations at

1 the heading at the bottom.

2 A. Can you repeat the question?

3 Q. On page eight, the authors admit that the
4 studies cross-sectional study design precludes
5 determination of causation.

6 Correct?

7 A. That is correct.

8 Q. The authors also admit that those with worse
9 mental health or internalized transphobia may have been
10 more likely to seek out conversion therapy rather than
11 non GICE therapy suggesting conversion efforts itself
12 were not causative of these poor mental health outcomes.

13 Correct?

14 A. That is what is written, correct.

15 Q. Okay.

16 So this study does not establish a causal link
17 between conversion therapy and suicidality.

18 Correct?

19 A. That is correct.

20 Q. The authors also admit that they lack data
21 regarding the degree to which GICE occurred.

22 Correct?

23 A. That is correct.

24 Q. And they also admit that they lacked information

1 as to what specific modalities were used.

2 Correct?

3 A. That is correct.

4 Q. Turban et al., in 2020 also admits that
5 participants were not recruited via random sampling and
6 thus the sample may not be nationally representative.

7 Is that correct?

8 A. That is correct.

9 Q. In paragraph 37 you go on to say that
10 conclusions further supported by extensive evidence that
11 rejection of a young person's gender identity by family
12 and peers is the strongest predictor for adverse mental
13 health outcomes.

14 Is that correct?

15 A. That is correct.

16 Q. And you cite in that article --- you cite in
17 footnote seven an article by Ryan, et al. published in
18 2010.

19 Is that correct?

20 A. I'm not seeing that.

21 Q. In footnote seven?

22 A. Oh, in footnote seven, yes.

23 ATTORNEY BARHAM: I'm going to show you
24 what we will mark as Exhibit-44, which is Tab 114, an

1 article by Ryan, et al. published in 2010 entitled
2 Family Acceptance in Adolescence and the Health of LGBT
3 Young Adults.

4 ---

5 (Whereupon, Exhibit-44, Article by Ryan,
6 et al., was marked for identification.)

7 ---

8 BY ATTORNEY BARHAM:

9 Q. This is the article that you cited in footnote
10 seven of your report.

11 Correct?

12 A. That is correct.

13 Q. On page 206, in the second column, the authors
14 note that they relied on a sample of 245 people.

15 Is that correct?

16 A. That is correct.

17 Q. Of that sample, only nine percent identified as
18 transgender.

19 Correct? That's on page 208.

20 A. Correct.

21 Q. That means we're talking about nine people.

22 Correct? 245 times nine percent is 22.05.

23 A. I'll take your math.

24 Q. On page 210 the authors admit that they cannot

1 claim that this sample is representative of the general
2 population of LGBT individuals.

3 Is that correct?

4 A. That is correct.

5 Q. On page 210 to 211 the authors recognize that
6 this is a retrospective study, which, quote, allows for
7 the potential of recall bias in describing specific
8 family reactions to their LGBT identity.

9 Correct?

10 A. That is correct.

11 Q. And then in footnote seven of your report you
12 also cite an article by Klein and Golub published in
13 2016.

14 Correct?

15 A. That is correct.

16 Q. All right.

17 ATTORNEY BARHAM: I'm going to show you
18 what we will mark as Exhibit 45, which is Tab 15.

19 ---

20 (Whereupon, Exhibit-45, Article by Klein
21 and Golub, was marked for
22 identification.)

23 ---

24 BY ATTORNEY BARHAM:

1 Q. This is an article by Klein and Golub entitled
2 Family Rejection as a Predictor of Suicide Attempts.
3 This article simply says that family rejection is a
4 predictor of suicide attempts and substance abuse among
5 transgender and gender non-conforming adults.

6 Correct?

7 ATTORNEY BLOCK: Objection. Can you
8 point to where you are reading from?

9 ATTORNEY BARHAM: The title.

10 THE WITNESS: They identify as a
11 predictor, yes.

12 BY ATTORNEY BARHAM:

13 Q. In fact, the word strongest does not even appear
14 in this article.

15 Is that correct?

16 ATTORNEY BLOCK: Objection.

17 THE WITNESS: I would have to read the
18 whole article.

19 ATTORNEY BLOCK: Let him read it.

20 THE WITNESS: The authors note on
21 page 195 on a multi-variant model moderate levels of
22 family rejection were associated with almost twice the
23 odds of attempted suicide and high levels of family
24 rejection were associated with almost three and a half

1 times the odds of attempted suicide. While there is not
2 any use of the word stronger, I don't see any additional
3 risks that were highlighted in this specific study.

4 BY ATTORNEY BARHAM:

5 Q. Okay.

6 On page 197 stemming over on to 198 the authors
7 admit that they relied on data NTDS that use sampling
8 techniques that were not random and included a
9 homogenous study population that was largely white,
10 educated and employed.

11 Correct?

12 A. That is correct.

13 Q. Do you agree with them that this limits the
14 generalizability of the article's findings?

15 A. I do.

16 Q. The authors also admit that the cross sectional
17 nature of the data did not allow us to determine any
18 causal relationship between family rejection and the
19 negative health-related outcomes.

20 Correct?

21 A. Correct.

22 Q. The authors also indicate that they did not have
23 any information about the timeframe within which family
24 rejection occurred, including what precipitated the

1 event, the severity of the rejection or whether this
2 changed over time.

3 Correct?

4 A. Correct.

5 Q. Do you agree with them that these factors might
6 have influenced their results?

7 A. Sure.

8 Q. All right.

9 Let's go to Tab 97, which is Exhibit 16. This
10 article we discussed before, but this reviews the Turban
11 article that you cited in footnote seven of your report.

12 Is that correct?

13 A. That is correct.

14 Q. Or footnote six of your report. Okay.

15 And in your report you are using the Turban
16 2020 article to critique the use of what you describe as
17 conversion therapy.

18 Is that correct?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: I'm just pulling this up
21 where I have it. As I stated in my report, the Turban
22 article found that people who reported experiencing
23 those conversion efforts were more likely to have
24 reported attempting suicide.

1 BY ATTORNEY BARHAM:

2 Q. So you're using it to critique what you
3 described as conversion therapy.

4 Is that fair?

5 A. I think that's fair.

6 Q. On page two of Dr. D'Angelo's letter to the
7 editor he notes at the top of the first --- towards the
8 top of the first column that Turban's analysis used data
9 from the 2015 USTS survey of transgender identifying
10 individuals, this survey is convenient sampling
11 methodology which generates lower quality data.

12 Would you agree that convenient sampling
13 generates low quality data?

14 A. Convenient sampling generates lower quality
15 data. And then some other statistical method of study
16 design. One of the ways that you want to counteract
17 that potential for low quality of data is to have
18 increased number of participants. The difference of
19 27,000 participants in this particular survey analysis
20 versus say 100 in another, 40 in another does add a
21 little bit more context to the applicability of these
22 findings.

23 Q. Right below that Dr. D'Angelo, et al. notes that
24 the participants were recruited through transgender

1 advocacy organizations and subjects were asked to pledge
2 to promote survey among friends and family. This
3 recruiting method yielded a large but highly skewed
4 sample. Would you agree that the sample for this survey
5 was highly skewed?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: I think we'd have to
8 understand what specifically you mean by skewed and
9 skewed in what way. It's hard to know.

10 BY ATTORNEY BARHAM:

11 Q. The authors go on in Table 1 to demonstrate what
12 they mean by skewing of the data. Upon reviewing their
13 information, would you agree that the sample was skewed?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: Again, I'm not sure skewed
16 in comparative --- comparison to what?

17 BY ATTORNEY BARHAM:

18 Q. The authors continue on page two by saying that
19 a number of additional data irregularities in the USTS
20 raise further questions about the quality of the data
21 captured by the survey. They talk about how high number
22 of survey participants had not transitioned medically or
23 socially, significant number reported no intention to
24 transition in the future. The information about

1 treatments does not appear to be accurate as a number of
2 respondents reported the initiation of puberty blockers
3 after the age 18, which is highly improbable. Further,
4 the survey has developed special waiting due to
5 unexpected high proportion of respondents who reported
6 that they were exactly 18 years old. Do you agree that
7 these irregularities raise serious questions about the
8 reliability of the data?

9 A. I think these are all elements that you want to
10 take into context as you're establishing validity of the
11 data and the conclusions that could be drawn.

12 Q. The second column of page two, the authors note
13 that the emphasis on the survey's goals to highlight the
14 injustices suffered by transgender people during the
15 recruitment stage in the introduction of the survey
16 instrument itself made it eligible for reporting adverse
17 experiences due to demand bias.

18 Do you agree that this demand bias likely
19 skewed the responses?

20 A. I wouldn't agree that it likely, but that
21 implies that we have data that we don't have. It's a
22 possibility that these authors are raising.

23 Q. Now, the authors also note that the experience
24 of detransitioners and the sisters were not included, as

1 they were disqualified from completing the survey. They
2 note that this failure is a serious oversight.

3 Do you agree with them that that's a serious
4 oversight?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: I would need to look at the
7 specific survey instructions for the survey in question
8 to understand the validity of that. I don't see how in
9 the context of this that folks who detransitioned were
10 specifically excluded, but ---.

11 BY ATTORNEY BARHAM:

12 Q. Did you review ---?

13 A. Can you point to where that --- where in the
14 original article or the study that those folks are
15 excluded specifically. I may have missed it.

16 Q. I don't have the original survey on hand at the
17 moment. If it proved that they were excluded, would you
18 agree that that would be a serious oversight?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: It would really depend on
21 how that was done and what the language was used.
22 Without seeing it I can't make a comment otherwise.

23 BY ATTORNEY BARHAM:

24 Q. What if there was no language involved, it was

1 just those who indicated that they were either desisting
2 or detransitioning or not included in the data set?

3 A. I would need to see the context of it in order
4 to make a judgment on the validity of that structure.

5 Q. On page four of this document. The authors note
6 that Turban's hypothesis is further weakened by a
7 significant flaw in their data analysis failure to
8 control for individuals pre-GICE exposure mental health
9 exposure status, noting that this is a potential
10 compound and may mask reverse causation.

11 Do you have any scientific basis for disputing
12 that concern?

13 A. Let me review this part of the paper, please.

14 ATTORNEY BLOCK: Just objection. I don't
15 think he read the full the sentence.

16 THE WITNESS: I have not seen any
17 literature on specific risks or predictors for
18 individuals who would be exposed to gender identity
19 conversion efforts, and so the supposition inherent in
20 this paragraph that the authors are making that an
21 individual's underlying poor mental health led to their
22 experience of gender identity conversion efforts is not
23 supported by my understanding of the literature.

24 BY ATTORNEY BARHAM:

1 Q. Do you have any reason to dispute a potential
2 for a confound or the potential for masking reversed
3 causation that the authors identify here?

4 A. As I described, I haven't seen any literature
5 that speaks to this nor has that been my clinical
6 experience.

7 Q. On page two of this document the authors note
8 that Turban's conclusions rest on the assumption that
9 they have a valid way of determining whether or not the
10 respondent was exposed to the unethical practice of
11 conversion therapy. Do you agree that this lack of
12 context in detail renders the question incapable of
13 differentiating between ethical non-affirming ---
14 non-affirmative neutral and counters unethical
15 conversion therapy?

16 A. I do not.

17 ATTORNEY BLOCK: Sorry, objection to
18 form.

19 BY ATTORNEY BARHAM:

20 Q. Back on page four the authors note that the
21 failure to control for the subjects' baseline mental
22 health makes it impossible to determine whether the
23 mental health or suicidality of a subject person stayed
24 the same or potentially even improved after the

1 non-affirming encounter. Do you have any scientific
2 basis for disputing this observation?

3 ATTORNEY BLOCK: Objection to form.

4 THE WITNESS: Again, if we wanted to go
5 back to the Turban study itself and look more
6 specifically at their methodology and their description
7 that would be a more accurate way of getting a potential
8 ups and downs side of this study other than this letter
9 to the editor.

10 BY ATTORNEY BARHAM:

11 Q. But do you have any basis for -- any scientific
12 basis for disputing that observation?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: This question gets to a
15 very specific type of study designed methodology. That
16 is something that typically is done by a data scientist,
17 which is not where my level of expertise is. There are
18 nuances in it. What I would say is in a population as
19 large of a survey that having a denominator as high as
20 they had helps to reduce the chances of confounders like
21 the authors in this letter to the editor are describing
22 as problematic.

23 BY ATTORNEY BARHAM:

24 Q. A little bit later on page five the authors

1 highlight the cross sectional design of the USTS and
2 indicate that presenting a highly confounded association
3 of causation is a serious error.

4 Do you agree that presenting a confounded
5 association as causation is a serious error?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: I have not claimed nor do I
8 understand my reading of the Turban, et al. article to
9 claim causation when an association has been found, and
10 in fact, they specifically called out that it was not
11 causative or at least the analysis could not prove it
12 was causative with a cross-sectional design.

13 BY ATTORNEY BARHAM:

14 Q. So when you wrote paragraph 34 of your report
15 and said that a study found that people who reported
16 experiencing these conversion efforts were more likely
17 to have reported attempting suicide, especially those
18 who reported receiving such therapy in childhood, were
19 you suggesting that the conversion efforts caused the
20 suicide attempts?

21 A. I believe in my testimony I am saying that there
22 is a relationship between those who are exposed to
23 conversion efforts and those who have described
24 reporting attempting suicide.

1 Q. And how would you describe that relationship?

2 A. As an association.

3 Q. Is association a synonym for correlation?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: It depends on the context,
6 but generally in plain English association and
7 correlation are relative synonyms for one another.

8 BY ATTORNEY BARHAM:

9 Q. In this specific context of your report, when
10 you say that you are reporting an association, were you
11 using association in correlation to synonyms?

12 A. As far as I know I was, yeah.

13 Q. Have you had patients impacted by not being
14 allowed to play sports consistent with their gender
15 identity?

16 A. On occasion, yes.

17 Q. Approximately how many such patients?

18 A. On the order of less than two or three.

19 Q. What sports were those patients participating
20 in?

21 A. I do not recall the specific. These were ---
22 the two or three that I had were all in the order of
23 between five, six and seven-year-olds.

24 Q. What was your follow-up with each patient?

1 A. With those particular kids?

2 Q. Yes.

3 A. Without having their charts in front of me, it's
4 hard to expound. My typical process would be
5 understanding why it's happening, what they need and how
6 to coordinate with whatever program to help make sure
7 that the kid gets the support that is going to be most
8 beneficial to them.

9 Q. Are you offering an opinion that the State of
10 West Virginia does not have a strong interest in
11 ensuring safe competition for women?

12 ATTORNEY BLOCK: Objection to form.

13 THE WITNESS: My testimony is about the
14 mental health impacts. I don't have an opinion on the
15 state interests of West Virginia in this regard.

16 BY ATTORNEY BARHAM:

17 Q. Are you offering an opinion that the State of
18 West Virginia does not have a strong interest in
19 ensuring fair competition?

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: Same answer.

22 BY ATTORNEY BARHAM:

23 Q. Would you agree that ensuring fairness and
24 safety is an important state interest.

1 ATTORNEY BLOCK: Objection to form and
2 scope.

3 THE WITNESS: Same answer.

4 ATTORNEY BARHAM: All right. I believe
5 those are all my questions for today. I will turn the
6 floor over to Mr. Tryon.

7 ATTORNEY TYRON: Okay.

8 Here I am.

9 ---

10 EXAMINATION

11 ---

12 BY ATTORNEY TRYON:

13 Q. My name's David Tryon. I am with the West
14 Virginia Attorney General's Office and represent the
15 State of West Virginia. So we've got about an hour
16 left. Do you want to just keep on going and finish up
17 or would you like to take a break for five minutes
18 before we finish up?

19 A. I think let's keep going. If I have to take a
20 break, I'll let you know. I appreciate it.

21 Q. Okay.

22 You bet. Happy to help you out that way again.
23 I just want to follow up, first of all, on a couple of
24 questions about the Turban study, if I may, that we were

1 just discussing. And Exhibit 16 I believe was the
2 document that addressed that Turban study.

3 A. I see Exhibit 16 as the letter to the editor
4 from D'Angelo, et al.

5 Q. And that's the one that we were just looking at
6 addressing the Turban study.

7 Right?

8 A. Correct.

9 Q. So let me just ask you, you did cite the Turban
10 study in your report.

11 Right?

12 A. Yes.

13 Q. Yeah, and that was to support your opinion.

14 Right?

15 A. That is to support my opinion, yes.

16 Q. Now, before you used it did you do something to
17 cite check it to see if there were any articles that
18 either challenged it or critiqued it or criticized it?

19 A. I would say that a routine review of the
20 literature is a part of my day-to-day practice. This
21 particular article did not come up in that review.

22 Q. Okay.

23 Is there a way to specifically search for it to
24 see if --- to look at it and then do a search and see

1 what other articles are quoted or cited?

2 A. My guess is there probably is, I'm not aware of
3 it.

4 Q. But I think you said you were not aware of the
5 letter which is Exhibit 16 prior to issuing your expert
6 report.

7 Is that right?

8 A. That is correct.

9 Q. Would it have been helpful to have seen that
10 ahead of time?

11 A. I think it would have been helpful for me to
12 feel more prepared in this deposition. I don't think it
13 would have changed any of my report.

14 Q. If you had that, would you have investigated
15 those criticisms to see if they were failed criticisms?

16 A. The authors of the Turban study had raised most
17 of those criticisms themselves in the context of their
18 report.

19 Q. And did you independently look at it and
20 determine if they were --- if that caused you some
21 concerns?

22 A. Concerns wouldn't be the right word. It's about
23 weighing the evidence and making sure that we understand
24 context and applicability. There's nothing in this

1 letter to the editor that changes those demands from my
2 reading of the Turban article.

3 Q. So you are saying that this letter in the Turban
4 article --- I'm sorry, you're saying this letter to the
5 editor does not raise any new issues at all than what
6 the Turban study itself raised.

7 Is that right?

8 A. I would have to read through this in a more
9 detailed manner to say for certain that no single issue
10 has been addressed. None of which we discussed today
11 are elements that hadn't been addressed, either by
12 myself reading the Turban article or by the Turban, et
13 al. in the article itself.

14 Q. But you do not raise any of those concerns in
15 your report, do you?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: No. No, not specifically.

18 BY ATTORNEY TRYON:

19 Q. Okay. Fair enough.

20 If you can follow your report now, which I'm
21 forgetting which exhibit that is, Exhibit 1. Thank you.

22 So first of all, you said you were retained by
23 Counsel for the Plaintiffs as an expert. Can you tell
24 me when you were retained, please?

1 A. I would have to pull up my invoice to give you
2 the specific date, and I'm guessing Mr. Block might have
3 that information at the ready.

4 Q. Unfortunately, I can't depose him. I would love
5 to, but I don't think he would agree to that. So as
6 best you can recall --- first of all, was it this year
7 or last year?

8 A. It was this year to the best of my recollection.

9 Q. Okay.

10 Was it after the other expert reports came out
11 or before?

12 A. I believe I was hired or retained. I don't know
13 what the correct terminology is so forgive me, after the
14 development of the additional expert reports. It was
15 the rebuttal to those reports that led to my being
16 retained to my recollection.

17 Q. I'm sorry?

18 A. From my recollection. And I'm terrible with
19 dates, so I apologize for that.

20 Q. In paragraph four, you say --- you explain what
21 you viewed and you mention the reports of Dr. Safer.
22 Does that refer to Dr. Safer's original report that was
23 filed with the Court and his rebuttal report --- strike
24 that.

1 Does that --- so he filed something with the
2 Court originally. Did you review that one?

3 A. It was the original report that I had reviewed.

4 Q. Okay.

5 So let me just be clear. So he filed an
6 original report back in --- last year and then issued a
7 new report in February of this year and then issued a
8 rebuttal report. So a total of three. Did you see all
9 three of those?

10 A. I would have to see them ---.

11 ATTORNEY BLOCK: Object to form.

12 THE WITNESS: I would have to see them in
13 front of me to know if it was something that I had read.
14 I don't know the terminology well enough to know if I
15 was reading the original report or rebuttal report or
16 the third type.

17 BY ATTORNEY TRYON:

18 Q. So one of them was expert report which was
19 issued I believe in February of this year. I believe
20 you saw that one.

21 A. Again, I would have to see the report in front
22 of me to know if it was the one I saw.

23 Q. Okay.

24 There was another one which was labeled as

1 rebuttal. Do you remember if you saw that one?

2 A. I would have to go back through my notes. I
3 don't have it in front of me, so I apologize for not
4 recalling.

5 Q. Well, let me ask you this question. Do you
6 remember how many reports you saw from Dr. Safer?

7 A. All I can say is I remember seeing at least two.

8 Q. Very good. And Dr. Adkins, how many of her
9 reports did you see?

10 A. I can't be certain, but I think I also saw two
11 of hers.

12 Q. And I'll represent to you that each of them
13 issued a rebuttal report. And did you read their
14 rebuttal reports prior to preparing your rebuttal
15 report?

16 A. I don't have the documentation in front of me in
17 terms of when I was spending time on what piece of this
18 process. That's a part of my notes that are not here
19 today.

20 Q. Do you know why you were asked to issue a
21 rebuttal report if Dr. Safer and Dr. Adkins were both
22 issuing rebuttal reports?

23 ATTORNEY BLOCK: Objection. Just don't
24 discuss any of the contents of your communications with

1 the attorneys.

2 ATTORNEY TRYON: Correct.

3 THE WITNESS: My understanding was to
4 rebut the reports of Dr. Levine and Dr. Cantor.

5 BY ATTORNEY TRYON:

6 Q. Is your rebuttal different than the rebuttals of
7 Dr. Adkins and Dr. Safer?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: Yes.

10 BY ATTORNEY TRYON:

11 Q. Pardon me?

12 A. Yes.

13 Q. Does your rebuttal report have any opinions
14 which are different from Dr. Safer and Dr. Adkins'
15 reports?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: I think it's hard without
18 the specific reports in front of me. I know they were
19 long documents and I was specifically rebutting the
20 reports of Dr. Levine and Cantor.

21 BY ATTORNEY TRYON:

22 Q. Do you have any specific reports that are not
23 rebutting Dr. Levine and Dr. Cantor?

24 A. The process of developing this rebuttal report

1 was for that specific intent.

2 Q. So you don't believe you have any original
3 opinions to report; would that be a fair statement?

4 ATTORNEY BLOCK: Objection to form.

5 THE WITNESS: I'm not --- I guess I'm not
6 sure what you mean by original opinions.

7 BY ATTORNEY TRYON:

8 Q. So let's move on. Do you recall the Costa
9 study?

10 A. Yes, we had reviewed one Costa study earlier.
11 Can you remind me of the exhibit number?

12 Q. I believe it's Exhibit 27?

13 A. All right. Okay.

14 Q. I believe that during that discussion you
15 referred to the standards in there as being rough or
16 imprecise measure and --- let me get this right, and not
17 objective criteria.

18 Do you remember that?

19 A. I had described the CGAS, the Children's Global
20 Assessment Scale, as an imprecise measure of children's
21 functioning.

22 Q. And you said not having any objective criteria;
23 can you help with that?

24 A. Yes, it's a scale from zero to a hundred that is

1 very gestalt that the clinician uses to rate a child.
2 It's not an instrument that I find clinically useful.

3 Q. Is it not clinically useful because it doesn't
4 have objective criteria?

5 A. I wouldn't say it's fair to say that there are
6 no objective criteria, but there are at times
7 contradictory objective criteria within the CGAS. And
8 again I would he have to see the CGAS in front of me to
9 point out those specifics, but there are other
10 functions, or other ways of measuring outcomes than the
11 CGAS.

12 Q. What is an objective criteria? What does that
13 term mean in other words?

14 ATTORNEY BLOCK: Objection to form.

15 THE WITNESS: I guess what would say is
16 we would want a psychometrically valid approach for
17 answering a question, ideally that is of clinical
18 relevance.

19 BY ATTORNEY TRYON:

20 Q. Can you just repeat your answer for me? I
21 didn't quite understand it.

22 A. Probably not the same language. A
23 psychometrically valid tool that in an ideal world
24 provides some kind of clinical relevance.

1 Q. Okay.

2 You said psychometrically valid tool.

3 Did I get that right?

4 A. Psychometrically validated tool, yes.

5 Q. Validated?

6 A. Yes.

7 Q. What is that?

8 A. Essentially you want to understand that the
9 measure you're using is measuring what it says to
10 measure and is reliable across multiple domains. The
11 CGAS has been widely used in research, it's just not my
12 favorite tool because I don't find it to have that
13 second domain of having that clinical utility.

14 Q. Let me ask you to take a look at paragraph 19 of
15 your opinion?

16 A. I'm looking at it now.

17 Q. You say at one point it says contrary to the
18 portrayal. Do you see that sentence?

19 A. I see that, yes.

20 Q. Contrary to the portrayal in Dr. Levine and Dr.
21 Cantor's reports, gender-affirming treatment also
22 requires a careful and thorough assessment of a
23 patient's mental health, including co-occurring
24 conditions, history of trauma, and substance abuse among

1 many other factors. My question for you is with respect
2 to your language, a careful and thorough assessment, and
3 I'd like to then know are there psychometrically
4 validated tools used to do that?

5 A. There are on occasion, and particularly when
6 we're looking at research outcomes for transgender youth
7 there are a number of psychometrically validated
8 screenings or outcome measures that are used.

9 Q. What are those?

10 A. These include most importantly the Utrecht
11 Gender Dysphoria Scale, the Body Image Scale,
12 historically what's in the Dutch data, the Toronto data,
13 and the Costa data and The Tavistock Clinic, all of them
14 were participatory in kind of the informal research
15 group that agreed to collect the same measures, so these
16 included the Achenbach, CBCL, and they use self report.

17 Q. I'm sorry. What was the first one you said
18 before Body Image Scale?

19 A. Utrecht Gender Dysphoria Scale.

20 Q. Utrecht Gender Dysphoria Scale?

21 A. Correct.

22 Q. What is that?

23 A. It's a measure of the degree and intensity of
24 gender dysphoria.

1 Q. How is it --- what does it look like? Does it
2 have a series of scale one to ten on different issues or
3 what is it?

4 A. It's a series of questions that I'd have to have
5 in front of me to give a better job of describing, but
6 it provides a rating of --- I can't remember what the
7 range is, from zero to somewhere in the low dozens, that
8 correlates with the intensity of gender dysphoria.

9 Q. Is that something that you use in your practice
10 to diagnose gender dysphoria?

11 A. It is an element that I have used.

12 Q. Do you use that with every patient?

13 A. It is not something that I use with every
14 patient. The contents of the Utrecht Gender Dysphoria
15 Scale are generally pieces that I'm getting or gathering
16 from every clinical encounter without necessarily
17 utilizing the specific tool.

18 Q. This statement, a careful and thorough
19 assessment, does that have a --- is there a source for
20 that particular standard?

21 A. There are a number of sources for this
22 particular standard. The general practice of children's
23 mental health from my guild in child adolescence
24 psychiatry, there are years of training and

1 certification in order for you to have demonstrated a
2 careful and thorough assessment. In order to get Board
3 Certified I had to do a careful and thorough assessment
4 in front of a board of examiners, so this is inherent to
5 the practice of mental health.

6 Q. Is there --- but there is no requirement that
7 these various standardized tools that you mentioned to
8 me, these psychometrically valid tools have to be used,
9 is there?

10 A. There isn't, and there is not a clinical
11 verification that they be used in every instance. For
12 the sake of these kind of studies, it's important to
13 have these validated tools so we're all speaking the
14 same language and that outcomes can be tracked over
15 time, but not necessarily in every clinical event is it
16 going to be warranted.

17 Q. If you don't use them in every clinical event,
18 then how can how can you adequately track something
19 across patients if you wanted to do a study?

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: As an example there are a
22 number of psychometrically validated tools that cannot
23 be administered at every clinical encounter, otherwise
24 they would be rendered invalid. So there's a lot of

1 nuance in these specific tools and I think that level of
2 nuance is really a clinical judgment based upon
3 professional and prevailing standards.

4 BY ATTORNEY TRYON:

5 Q. Okay.

6 So there's no objective measure of someone
7 other than --- well, let me back up. So different
8 psychiatrists would come up with different conclusions.

9 Is that right?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: I don't think that's
12 related to what I was speaking about. I think different
13 psychiatrists would utilize different instruments to
14 provide an assessment, and that's going to change from
15 person to person. I can't speak to diagnostic
16 reliability for a psychiatrist that I haven't met or
17 trained.

18 BY ATTORNEY TRYON:

19 Q. Let me ask you how long you would normally spend
20 with a child before --- or adolescent before prescribing
21 puberty blockers?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: There is not going to be a
24 single answer to that question. It really is dependent

1 on the requirements of the assessment, as well as the
2 individual factors of that child and that family.

3 BY ATTORNEY TRYON:

4 Q. Could ten minutes be long enough?

5 A. Not in my opinion.

6 Q. What about 30 minutes?

7 A. Likely not.

8 Q. How about an hour?

9 A. It would be very atypical in my practice to
10 spend that little time prior to making a recommendation
11 for puberty suppression. I do a much more thorough
12 assessment than an hour.

13 Q. So how long would a thorough assessment normally
14 take?

15 ATTORNEY BLOCK: Objection to form.

16 BY ATTORNEY TRYON:

17 Q. You said more than an hour I think?

18 A. Correct. I would say more than an hour. I
19 think maybe there's a ceiling, but not a roof. What I
20 mean by that that is there are certain criteria required
21 in order to make a recommendation for a treatment for
22 gender dysphoria to be offered. Those include a
23 diagnosis of gender dysphoria, a recognition of any
24 co-occurring mental health issues and whether or not

1 they are adequately well controlled enough to be able to
2 proceed with care. And a clear understanding of the
3 risks, benefits and alternatives of that treatment.
4 There's no specific timeframe on that as an assessment.

5 Q. How many visits would you expect to be adequate
6 for a careful and thorough assessment?

7 ATTORNEY BLOCK: Objection to form.

8 THE WITNESS: And I apologize, it's ---
9 I'm not trying to be evasive. It really is going to
10 depend upon each individual child.

11 BY ATTORNEY TRYON:

12 Q. What about is one enough? Have you ever done it
13 --- given a recommendation for puberty blocker after
14 only one visit for an hour?

15 ATTORNEY BLOCK: Compound question.

16 THE WITNESS: I have never given a
17 recommendation for puberty suppression after a one hour
18 visit personally.

19 BY ATTORNEY TRYON:

20 Q. What's the minimum time that you think is
21 adequate?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: As I said, I don't think
24 it's based on time. It's based about the content.

1 There are circumstances in which patients have been
2 followed for several years by therapists, that can
3 provide a tremendous amount of collateral information
4 including information provided by parents, family
5 members, community providers, et cetera, that can allow
6 more abbreviated assessment for some people.

7 BY ATTORNEY TRYON:

8 Q. Is someone as consistently spending only an hour
9 with one patient, with each patient for recommending
10 puberty blockers, that would look kind of like a rubber
11 stamp recommendation wouldn't it?

12 ATTORNEY BLOCK: Objection.

13 BY ATTORNEY TRYON:

14 Q. Assuming that it's happening?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: I would have to see the
17 specifics in order to make any kind of comment.

18 BY ATTORNEY TRYON:

19 Q. Isn't it fair for Dr. Levine or Cantor to
20 express concern that in actual practice that may be
21 happening?

22 ATTORNEY BLOCK: Objection to form.

23 THE WITNESS: I have not seen anywhere in
24 Dr. Cantor or Dr. Levine's report or within the

1 literature that this is a pervasive thing that is
2 happening.

3 BY ATTORNEY TRYON:

4 Q. Well, it's not tracked at all so we wouldn't
5 know, would we, one way or the other?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: It is a question that could
8 be asked. I don't think it's for me to make
9 suppositions, nor do I think it is for Dr. Cantor and
10 Dr. Levine to make suppositions about the critical care
11 of transgender youth in this context.

12 BY ATTORNEY TRYON:

13 Q. Is there any --- is there any place where you
14 report any central location where you or your clinic
15 report how much time and effort and what your thorough
16 examination is so that it can be tracked?

17 A. The site where I'm at now is part of a four-site
18 NIH trial that has published on the specific assessment
19 processes that the kids who are involved in the study
20 engage in.

21 Q. How many kids are in that trial?

22 A. I'm not a specific participant in the
23 organization of that trial, so I don't have that
24 information in front of me.

1 Q. Does your clinic report to that trial?

2 A. My gender clinic, the gender clinic within the
3 hospital that I work in, there are many patients who are
4 enrolled in that trial, yes.

5 Q. But it's certainly not mandated, right?

6 A. No.

7 Q. When these careful and thorough assessments are
8 done, what type of documentation should be used for
9 that?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: That's a very contextual
12 question. We have prevailing standards in terms of what
13 should and shouldn't be documented through various
14 professional organizations, but that's going to change
15 from state to state, country to country.

16 BY ATTORNEY TRYON:

17 Q. And what about in the State of West Virginia?

18 A. I have no knowledge of documentation
19 requirements in the State of West Virginia.

20 Q. How about in the United States in general?

21 A. As far as I'm aware, there are no universal
22 recommendations in terms of specifics of how things are
23 documented.

24 Q. Are there any organizations like the WPATH or

1 any other organizations that do give recommendations on
2 what documentation to use in America?

3 A. WPATH has certainly provided some educational
4 events in terms of best practices in documenting, but
5 these aren't specific guidelines or recommendations. I
6 think it is notable to say that the Dutch clinic in
7 particular has been quite vigorous in their production
8 of research and is quite well respected in the world in
9 terms of how things are structured, and they actually
10 don't even have a letter that their clinicians write
11 and/or see initiation of puberty suppression for
12 gender-affirming hormones.

13 ATTORNEY TRYON: Jake, if you could bring
14 up the exhibit entitled Adolescent Medicine,
15 Confidential Patient Questionnaire, which has been
16 redacted?

17 VIDEOGRAPHER: Do you want that marked?

18 ATTORNEY TYRON: Yes, please, wherever we
19 are at in the next number.

20 VIDEOGRAPHER: I believe we're at 44.

21 LAW CLERK WILKINSON: 46.

22 ATTORNEY SWAMINATHAN: 46.

23 ---

24 (Whereupon, Exhibit-46, Form, was marked

1 for identification.)

2 ---

3 ATTORNEY TRYON: If you could bring that
4 up, Jake.

5 VIDEOGRAPHER: Yes. Give me one second.
6 I'm just marking that right now. We might have to mark
7 this one physically. The program won't mark it because
8 it's a redacted document.

9 ATTORNEY TRYON: Okay. Then we'll do
10 that to bring that up. And then, if you could, Jake,
11 just scroll down in this. I just have a couple
12 questions about this form.

13 THE WITNESS: Okay.

14 ATTORNEY TRYON: Go onto the next page
15 down.

16 BY ATTORNEY TRYON:

17 Q. Have you ever seen a form like this?

18 ATTORNEY BLOCK: Objection to form. No
19 pun intended.

20 THE WITNESS: Could you be a little more
21 specific? I mean, I've seen --- this is kind of very
22 typical for a lot of intake-type documents in mental
23 health clinics or in medical clinics.

24 BY ATTORNEY TRYON:

1 Q. So you would characterize this as a typical
2 intake form?

3 ATTORNEY BLOCK: Objection.

4 THE WITNESS: I wouldn't characterize it
5 in that way. I have seen typical intake forms that
6 resemble this in some ways.

7 BY ATTORNEY TRYON:

8 Q. Would this be something that you would consider
9 adequate to document a careful and thorough assessment?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: Again, without knowing the
12 context of the individual's practice, it's impossible
13 for me to say.

14 BY ATTORNEY TRYON:

15 Q. Is this a form that you would use for careful
16 and thorough assessment of a patient's mental health?

17 ATTORNEY BLOCK: Objection to form.

18 THE WITNESS: I don't use this form. I
19 can't say whether or not I was in the context this
20 provider was practicing that I wouldn't use this form as
21 part of my assessment.

22 BY ATTORNEY TRYON:

23 Q. Fair enough. Do you use it as a part of your
24 careful thought thorough assessment of the patient's

1 mental health, are there any other forms that you expect
2 to see in the caregiver's file about that patient's
3 mental health?

4 A. Not specifically.

5 Q. This would be adequate?

6 ATTORNEY BLOCK: Objection to form.

7 THE WITNESS: Again, I can't speak to
8 the adequacy of it without understanding the context of
9 the rest of the treatment.

10 BY ATTORNEY TRYON:

11 Q. Is there any certification that you think is
12 necessary or appropriate for someone to diagnose gender
13 dysphoria?

14 A. There is no universal certification process.
15 What we have are guidelines and recommendations for
16 ensuring that folks from the mental health perspective,
17 again, medical professionals are able to diagnose gender
18 dysphoria, but from the mental health perspective, it's
19 recommended that we are licensed clinical professionals
20 that have some, if not an expert level of understanding
21 of gender identity issues and having continuing
22 education in the field. These are ongoing
23 recommendations. I wouldn't say it was the expertise,
24 but knowledge about standard of care that's congruent

1 with how other disorders are also treated.

2 Q. Let me ask you about paragraph 16 of your
3 report.

4 Do you see the last sentence there?

5 A. Yes.

6 Q. It says HB-3293 does not affect elementary
7 students --- elementary school students who are
8 transgender boys?

9 A. Yes.

10 Q. So you previously testified that puberty is ---
11 starts on the average about age 12 for males.

12 Right?

13 ATTORNEY BLOCK: Objection to form.

14 THE WITNESS: Again, I would defer to our
15 --- that's an answerable question based upon national
16 data that I don't have in front of me, but 12-ish is,
17 yes.

18 BY ATTORNEY TRYON:

19 Q. And the range would be --- from what I read, the
20 range is generally between 8 and 14 years old.

21 Right?

22 A. Again, I would defer to my endocrine colleagues,
23 but yes, that's --- that's pretty typical.

24 Q. And you're aware that boys go into Middle School

1 as early as 11 years old or sometimes even earlier.

2 Right?

3 A. I can't say that I'm familiar with how each
4 state organizes their primary and secondary education
5 systems. I'm familiar with how it was in New York and
6 Illinois, and that was occasionally the case.

7 Q. So if an 11-year-old who has not gone through
8 puberty is in Middle School, then this would definitely
9 apply to some pre-pubescent children.

10 Right?

11 ATTORNEY BLOCK: Objection to form.

12 BY ATTORNEY TRYON:

13 Q. I'm sorry, I didn't make that clear. So if
14 there are prepubescent boys that are in middle school,
15 then HB-3293 would affect them.

16 Right?

17 A. I would have to put HB-3293 in front of me to
18 --- to know specifically. I'd have to refamiliarize
19 myself with it, the specifics of it.

20 Q. I'm sorry to interrupt you.

21 A. Yeah, I wouldn't want to comment on something I
22 don't have in front of me right now.

23 Q. Okay.

24 So just so you know I had to relocate from my

1 office to my home, and there's a poodle in here that you
2 may hear. So forgive if you hear the interruption.

3 ATTORNEY BLOCK: Objection to the
4 poodle.

5 ATTORNEY TRYON: Let me take one second.
6 I will be right back.

7 THE WITNESS: Maybe now is a good time
8 for bathroom break.

9 ATTORNEY BLOCK: Let's go off the record.

10 VIDEOGRAPHER: Going off the record the
11 time reads 5:46 p.m.

12 OFF VIDEO

13 ---

14 (WHEREUPON, A SHORT BREAK WAS TAKEN.)

15 ---

16 ON VIDEO

17 ATTORNEY TYRON: Okay let's go back on
18 the record.

19 VIDEOGRAPHER: Back on the record the
20 current time reads 5:50 p.m.

21 BY ATTORNEY TRYON:

22 Q. Let me direct you to paragraph 26 of your
23 report?

24 A. Yep.

1 Q. So there's the --- let's see, starting with the
2 word prepubertal children who he insists are children
3 with non-conforming gender expression who realize at the
4 onset of puberty that their gender identity is
5 consistent with their sex assigned at birth. Their
6 understanding of their gender identity changes at the
7 onset of puberty, but their gender identity does not.
8 So that's really a circular argument unless there's some
9 objective external way of proving what that child's
10 gender identity actually is, wouldn't you agree?

11 ATTORNEY BLOCK: Objection to form.

12 THE WITNESS: I think that the research
13 that we have on inherent gender identity is relatively
14 recent and needs a little bit more robust follow-up.
15 What we have are studies of cognition as well as some
16 very limited brain imaging studies that point to some
17 element of gender identity that has an objective
18 criteria to it. These are not studies that are
19 significant enough or have enough participants for us to
20 draw any kind of significant conclusions, but it does
21 speak when paired with clinical experiences of kids who
22 have desisted that the way that they describe their
23 identity is that it is not a fix or a change in their
24 sense of self but more about the expression of their

1 behaviors and their understanding of how they fit into
2 the world that has changed.

3 Q. So as you say it's too early to really know for
4 sure which of these things it is, right?

5 ATTORNEY BLOCK: Objection to form.

6 THE WITNESS: What I would say is it's a
7 preponderance of clinical experience and the studies
8 that we do have point to this being much more likely.

9 BY ATTORNEY TRYON:

10 Q. Much more likely, is that your testimony?

11 A. Based on my clinical experiences, yes.

12 Q. But there's no way that anyone outside of ---
13 there's no objective measurement to make that
14 determination, right?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: The way that I would
17 describe it is that gender dysphoria as a diagnosis
18 includes both identity-based criteria that are objective
19 and are measured through the course of the scales that
20 we talked about earlier, as well as measures of role and
21 behavior and congruence with your body. These are
22 things that are tracked over time in the studies that we
23 have, and when a child desists from that diagnosis of
24 gender dysphoria it is clear at that point that it was

1 primarily the gender role based behaviors that were
2 leading to this diagnosis as opposed to a change in
3 identity.

4 BY ATTORNEY TRYON:

5 Q. You were freezing up on me, so let me just see
6 if I can understand this by looking at the
7 transcription. If a child explains the reasons why he
8 or she has a different gender identity, that his or her
9 natal sex, the natal sex designation then later says the
10 opposite, there is really no way of telling whether or
11 not it's just the person's gender identity or the
12 understanding of the identity has changed based on that
13 child's or person's statements.

14 Right?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: I would say to complicate
17 matters even further, a number of the studies that are
18 used to describe this desistance phenomenon were first
19 carried out under the DSM-IV. On the DSM-IV the
20 diagnosis was gender disorder in childhood. And in that
21 nomenclature, an identity that is incongruent with sex
22 assigned at birth was not one of the required elements.
23 And so there are children who are described in the
24 common parlance as transgender because they met criteria

1 for what was then gender identity disorder, who
2 nevertheless discussed any identity incongruent with
3 their sex at birth. So that makes it hard to draw firm
4 conclusions about data captured under the DSM-IV.

5 BY ATTORNEY TRYON:

6 Q. And you are familiar with that diagnostic and
7 statistical manual of mental disorders.

8 Right?

9 A. I am.

10 Q. And you cited it in your reports.

11 Right?

12 A. Correct.

13 Q. That is a manual to assist in the diagnosis of
14 mental disorders.

15 Right?

16 A. That is correct.

17 Q. Is there a value of to classifying a condition
18 as a mental disorders?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: I don't know if I can offer
21 an expert opinion on that. I have a biased --- talk
22 about a selection bias as a psychiatrist and a mental
23 health professional. I think it's important for us to
24 destigmatize mental illness as much as possible, so

1 whatever is going to allow folks access to care, I'm
2 relatively neutral on placing a value on whether or not
3 something is a diagnosis or not.

4 BY ATTORNEY TRYON:

5 Q. A manual does not recommend any treatments, only
6 tools for diagnosis.

7 Is that right?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: The main goal of DSM for
10 classifying diagnoses and ensuring stability or
11 reliability of those diagnoses across practice
12 locations.

13 BY ATTORNEY TRYON:

14 Q. That does not recommend or even provide any
15 treatments.

16 Right?

17 A. The text of the DSM often recommends or
18 describes treatments.

19 Q. Does it describe treatments for gender
20 dysphoria?

21 A. The text was recently revised for gender
22 dysphoria, and so I really want to see the text in front
23 of me for me to talk about it.

24 Q. So in the DSM-V you don't know if it has any

1 recommendations for treatments in it for gender
2 dysphoria?

3 A. I don't know in the revised text how much was
4 changed without familiarizing myself with it. And I'm
5 happy to look at it. It's a quick read, but primarily
6 the DSM-V as it comes to gender dysphoria is a
7 description of the phenomenology not a recommendation
8 for treatments.

9 Q. And when was it revised?

10 A. It was just released about a week ago, maybe
11 two.

12 Q. Let me ask you to take a look at your report,
13 paragraph 51. You say to the contrary, as noted
14 previously, stigma and discrimination have been shown to
15 have a profoundly harmful impact on the mental health of
16 transgender people and other minority groups. Now, when
17 you say stigma and discrimination, you're not referring
18 specifically to not allowing, as using your term, a
19 transgender girl to participate on a girls sports team
20 to be that type of stigma or discrimination, are you?

21 ATTORNEY BLOCK: Objection to the form.

22 THE WITNESS: The reference that I
23 referred to in my report I would want to look at,
24 because they had an operational term for stigma and

1 discrimination. However, there has been literature, I
2 can't remember the names of the authors or the date of
3 the study, that look at specific laws that are enacted
4 to discriminate against LGBT people and impact on both
5 mental health and medical health, and so those kind of
6 discrimination laws certainly do have real felt impact
7 for transgender folks.

8 BY ATTORNEY TRYON:

9 Q. So are you saying that this sentence is
10 referring to a law such as HB-3293 or not?

11 A. I think, as I stated, for the sake of this
12 expert report, the Yhuto reference from 2015 is what I'm
13 using to craft that statement.

14 Q. I'm sorry, the what from 2015?

15 A. Footnote number 21.

16 Q. What are those profound impacts of mental health
17 that you are referring to?

18 A. Well, as I mentioned earlier in my report are
19 correlation between many exposures that transgender
20 individuals have and increased rates of suicide, self
21 harm, substance use, exposure to trauma that have
22 certainly profound negative impacts for the folks who
23 are experiencing them.

24 Q. And of those harms that you have just mentioned

1 are you aware of any of them caused by --- to a child or
2 person who was not --- who was a transgender female not
3 allowed to participate on a girls or woman's athletic
4 team?

5 A. As I had testified to earlier, I think I said
6 I've had two or three patients who are excluded from
7 sports teams, one of which was a child who was assigned
8 male at birth, who at age six was not allowed to
9 participate in the sport. I can't remember what support
10 it was. This was a child who was heckled and kicked out
11 of the group of friends that were participating in that
12 sport which led to negative mental health consequences
13 for that individual child.

14 Q. What specific --- I presume that's thoughts of
15 suicidality.

16 Right?

17 A. Thankfully at that age they were not.

18 Q. How did that child adapt to the situation?

19 A. Well, we worked with the child, the family and
20 the sports team, to understand what this child may need
21 and ended up --- I think it was T ball, I think ended up
22 joining the T ball team.

23 Q. So how much --- how much of a delay was there
24 between wanting to join the T ball team and being

1 allowed to join the T ball team?

2 A. This was years ago, so I don't recall the
3 specifics.

4 Q. Would it be your testimony that any delay at all
5 between the time of identifying for a natal male
6 identifying as a female and participating on a female
7 team would be profoundly harmful?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: I have not seen any studies
10 that have asked that question or could speak to the
11 duration of time between exclusion from an activity and
12 the mental health impacts.

13 BY ATTORNEY TRYON:

14 Q. Is it your position that as soon as the child or
15 person who is a natal male determines or identifies as a
16 female, that that person should be immediately allowed
17 to play on female teams?

18 ATTORNEY BLOCK: Objection to form and
19 scope.

20 THE WITNESS: I'm not able to answer that
21 question. I think that's out of the scope of my
22 expertise.

23 BY ATTORNEY TRYON:

24 Q. Let me ask it differently because I didn't ask

1 it quite as artfully as I could have. You indicated
2 profoundly harmful or have a profoundly harmful impact.
3 So if a child or adolescent or adult, adult meaning
4 anyone through collegiate age, were to be a natal male
5 and identify as a female and is not allowed to
6 immediately participate on female teams, would that be
7 profoundly harmful, would it have a profoundly harmful
8 impact on their mental health?

9 A. That would require an individualized assessment
10 of that child or young adult in order to understand the
11 potential impacts specific to that individual.

12 Q. What if they were required to wait a full year,
13 would that be profoundly --- have a profoundly harmful
14 impact on the mental health of that person?

15 ATTORNEY BLOCK: Objection to form.

16 THE WITNESS: Same answer.

17 BY BY ATTORNEY TRYON:

18 Q. Well as a general rule, do you have any opinion
19 as a general rule?

20 ATTORNEY BLOCK: Objection to form.

21 THE WITNESS: General rule of what? I'm
22 not understanding the question.

23 BY ATTORNEY TRYON:

24 Q. Let me try again. So is there --- do you have a

1 general --- I mean you made a generalized statement here
2 in the last sentence of paragraph 51. So my question
3 is, as it pertains to this generalized statement, is
4 there any delay that would not cause a profoundly
5 harmful impact on the mental health of transgender
6 people if they are denied the opportunity to immediately
7 participate in the sports team of their gender identity?

8 ATTORNEY BLOCK: Objection to form and
9 characterization.

10 THE WITNESS: It's a long sentence with a
11 lot of clauses. I'm trying to --- I'm trying to parse
12 them all out to make sure that I'm answering this
13 accurately. As I testified to in my report, there's
14 evidence of discrimination, stigma and bias leading to
15 individual harms. The specific manifestation of those
16 harms are highly individualized and require individual
17 assessment of each child and family in order to know.
18 Which is why you can't speak to the specific impacts for
19 each individual child, but what we know are
20 population-based data.

21 Q. Is it your view that if after a psychiatrist or
22 psychologist or appropriate healthcare individual
23 determines that there would be a profoundly harmful
24 impact that healthcare professional should be the one to

1 determine whether or not the child should be allowed to
2 participate on a girl's team?

3 A. I don't have a specific opinion about how sports
4 administration vary from state to state. I know it's
5 very different from state to state. What I would say is
6 from a mental health perspective my goal is to help our
7 kids access spaces that are going to be health promoting
8 and build resilience. I think it's important for health
9 professionals to be involved in the decisions that are
10 made, but I can't speak to the legislative process
11 within the scope of my expertise.

12 Q. Is the mental health of the cisgender females
13 who might be at a disadvantage of the participation of a
14 transgender female on the team, is their mental health
15 important?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: I would say first that the
18 mental health of cisgender children who have
19 participated in sports is certainly attestable
20 hypothesis to explore and it's not research that I have
21 seen, nor that I'm aware that it exists. Beyond that,
22 you know, my expertise does not extend to this
23 population as you have asked this question.

24 BY ATTORNEY TRYON:

1 Q. So then let me ask that specifically, have you
2 treated any cisgender females that have been upset about
3 transgender females participating on the girls team?

4 A. I have treated cisgender girls who have had
5 transgender teammates. I have not treated anybody who
6 has expressed any concern or harm from that.

7 Q. Do you acknowledge that there are those
8 cisgender girls who are suffering from psychological
9 harm from that?

10 ATTORNEY BLOCK: Objection to form.

11 THE WITNESS: I would not acknowledge
12 that. That is not data that I have seen nor has been my
13 personal experience with patients that I have seen or
14 other colleagues who have described this.

15 BY ATTORNEY TRYON:

16 Q. Are you aware that some of Lia Thomas' cisgender
17 teammates are very upset about Lia Thomas participating
18 on the female swimming team?

19 ATTORNEY BLOCK: Objection to form.

20 THE WITNESS: I haven't read much about
21 Lia Thomas or her teammates prior to today, so I'm not
22 aware of any specifics to that.

23 BY ATTORNEY TRYON:

24 Q. Have you read anything about that incident ---

1 excuse me, that situation?

2 A. Well, I've read something today.

3 Q. Prior to today?

4 A. Which did not mention about teammates being
5 upset. I've heard about it, but I have not read it.

6 Q. So you're aware of it?

7 A. I'm vaguely aware of it, yes. I've not done any
8 primary research into it.

9 ATTORNEY BLOCK: Could we get a time
10 check?

11 VIDEOGRAPHER: It looks like I got about
12 three minutes left.

13 ATTORNEY TRYON: I speak really fast.

14 BY ATTORNEY TRYON:

15 Q. Well, is there benefits in --- for example, you
16 said that HB --- you've read HB-3293 and you're aware
17 that it does require --- well, first of all, are you
18 aware that HB-3293 does not use the word transgender at
19 all or trans woman or trans girl at all?

20 A. I would want to look at it specifically to
21 double check that that's correct, but I would take your
22 word for it.

23 Q. And so in HB-3293, it does require that all
24 biological males must --- let me rephrase that, that

1 biological males may not compete on girls teams.

2 Do you understand that?

3 A. I don't, because biological male as a term is
4 certainly up for debate.

5 Q. Which word would you like to use?

6 A. I don't know if there's going to be an answer
7 for that in the context of this particular bill. I
8 think ---.

9 Q. How about natal male, does that work?

10 A. Sure. We can use that. I would typically use
11 assigned male at birth, but yes.

12 Q. Okay.

13 So natal males under this Bill are not allowed
14 to participate on girls sports teams.

15 Do you understand that?

16 ATTORNEY BLOCK: Objection to form.

17 THE WITNESS: Yeah. And I apologize I
18 really don't mean to be parsing, if the text of the Bill
19 is biological males, what that just means is that that
20 is a complex term that doesn't have a universal
21 acceptance. But I understand that the goal of the Bill
22 is for folks assigned male at birth, not to participate
23 in women's sports teams, yes.

24 BY ATTORNEY TRYON:

1 Q. If a --- to use your term, a person assigned
2 male at birth is told that that person may not
3 participate on girls sports, and as in so many other
4 things in life, you are told that's the rule and you
5 have to live with it, is there value in learning coping
6 skills to deal with rules that you don't agree with and
7 abide by them?

8 ATTORNEY BLOCK: Objection to form.

9 THE WITNESS: I guess the way I would
10 approach it is that if we look at the data, clinical
11 experiences and from the testimonies of transgender
12 individuals that they face enough on a daily basis
13 stigma discrimination exclusion, that they all would
14 benefit from a healthy development of coping skills.
15 Nowhere in the field of psychiatry is it recommended
16 that we expose people to traumatic events for them to
17 develop coping skills to manage through.

18 BY ATTORNEY TRYON:

19 Q. Well, not to intentionally do so, but there's
20 laws and rules that you made that said you have to live
21 with those rules then it's your position that the rules
22 need to be changed to comply with the wishes of that
23 person?

24 ATTORNEY BLOCK: Objection to form.

1 THE WITNESS: Again my expert testimony
2 is rebutting the testimony of Dr. Levine and Cantor. I
3 can't speak to the specific legislative processes in
4 terms of the best way for states to approach a complex
5 issue such as this.

6 ATTORNEY TRYON: I have no further
7 questions. Thank you for your time I appreciate it.

8 THE WITNESS: Thank you. What is your
9 poodle's name? Can I ask that off the record?

10 ATTORNEY BLOCK: We don't have any
11 Redirect questions. Dr. Janssen will review the
12 transcript.

13 ATTORNEY GREEN: This is Roberta Green on
14 behalf of WVSSAC. No questions.

15 ATTORNEY MORGAN: This is Kelly Morgan on
16 behalf of the West Virginia Board of Education and
17 Superintendant Burch. I don't have any questions.
18 Thank you.

19 ATTORNEY DENIKER: Dr. Janssen, thank you
20 for your time today, this is Susan Deniker. I have no
21 questions.

22 THE WITNESS: Thank you, guys.

23 VIDEOGRAPHER: Going off the record. The
24 current time reads 6:18 p.m.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

* * * * *

VIDEOTAPED DEPOSITION CONCLUDED AT 6:18 P.M.

* * * * *

1 STATE OF WEST VIRGINIA)

2 CERTIFICATE

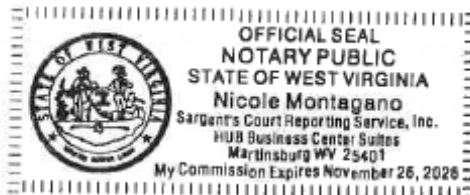
3 I, Nicole Montagano, a Notary Public in
4 and for the State of West Virginia, do hereby
5 certify:

6 That the witness whose testimony appears
7 in the foregoing deposition, was duly sworn by me
8 on said date, and that the transcribed deposition
9 of said witness is a true record of the testimony
10 given by said witness;

11 That the proceeding is herein recorded
12 fully and accurately;

13 That I am neither attorney nor counsel
14 for, nor related to any of the parties to the
15 action in which these depositions were taken, and
16 further that I am not a relative of any attorney
17 or counsel employed by the parties hereto, or
18 financially interested in this action.

19 I certify that the attached transcript
20 meets the requirements set forth within article
21 twenty-seven, chapter forty-seven of the West
22 Virginia.



Nicole Montagano
Nicole Montagano,
Court Reporter